United Nations A/HRC/32/44

General Assembly

Distr.: General
8 April 2016

Original: English

Human Rights Council
Thirty-second session
Agenda item 3
Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Report of the Working Group on the issue of discrimination against women in law and in practice

Note by the Secretariat

The Secretariat has the honour to transmit to the Human Rights Council the report of the Working Group on the issue of discrimination against women in law and in practice pursuant to Council resolutions 15/23 and 26/5. In its report, the Working Group addresses the issue of discrimination against women with regard to health and safety. The instrumentalization of women's bodies lies at the heart of discrimination against women, obstructing the achievement of their highest attainable standard of health. The Working Group highlights in particular the health and safety situation of women who experience discrimination on multiple and intersectional grounds. Women's non-discriminatory enjoyment of the right to health must be autonomous, effective and affordable and the State has the primary responsibility to respect, protect and fulfil women's right to health in law and in practice, including where health services are provided by private actors.

GE.16-05771(E)

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Contents

		Page
I.	Introduction	3
II.	Activities	3
	A. Sessions	3
	B. Country visits	3
	C. Communications and press releases	4
	D. Other activities	4
III.	Thematic analysis: eliminating discrimination against women with regard to health and safety	4
	A. Conceptual framework	4
	B. Meaning of equality in women's health and safety	6
	C. Discriminatory practices	7
	D. Instrumentalization of women's bodies	12
	E. Autonomous, affordable and effective access to health care	16
IV.	Conclusions and recommendations	18
	A. General recommendations	19
	B. Equality and non-discrimination	19
	C. Instrumentalization of women's bodies	21
	D. Autonomous, affordable and effective access to health care	22

I. Introduction

1. The present report covers the activities of the Working Group on the issue of discrimination against women in law and in practice undertaken since the submission of its previous report (A/HRC/29/40) until March 2016. It focuses on an analysis by the Working Group of discrimination against women with regard to health and safety.

2. The roles of Chair-Rapporteur and Vice-Chair of the Working Group were carried out by Emna Aouij and Eleonora Zielinska, respectively, until June 2015, and at the time of writing are held by Eleonora Zielinska and Alda Facio, respectively.

II. Activities

A. Sessions

3. The Working Group held three sessions in Geneva during the period under review. At its thirteenth session (4-8 May 2015), it held consultations on women's health and safety, including their rights to reproductive and sexual health, with a number of stakeholders and experts, including representatives from the World Health Organization (WHO), the United Nations Population Fund, the United Nations Research Institute for Social Development , the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and civil society organizations as well as expert staff of the Office of the United Nations High Commissioner for Human Rights (OHCHR).

4. At its fourteenth session (12-16 October 2015), the Working Group continued its consultations on the issue of women's health and safety, including with experts from the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Inter-Parliamentary Union, the Committee on Economic, Social and Cultural Rights, the secretariats of OHCHR treaty monitoring bodies, the Special Rapporteur on the rights of persons with disabilities and members of civil society organizations. The Working Group exchanged views with Member States on its work and held a meeting with the United Nations High Commissioner for Human Rights.

5. At its fifteenth session (25-29 January 2016), the Working Group held a meeting with the Permanent Representative of the Organization of Islamic Cooperation to the United Nations Office at Geneva. It began its consultation on the development of a compendium of good practices and held a briefing with civil society organizations.

B. Country visits

6. The Working Group visited Senegal from 7 to 17 April 2015 (A/HRC/32/44/Add.1) and the United States of America from 30 November to 11 December 2015 (A/HRC/32/44/Add.2). It wishes to thank the Governments of these countries for their cooperation before and during the visits. It thanks the Governments of Hungary and Kuwait for responding positively to requests for visits, which will take place from 17 to 27 May 2016 and from 6 to 15 December 2016, respectively.

C. Communications and press releases

7. During the period under review, the Working Group addressed communications to Governments, individually or jointly with other mandate holders. The communications concerned a wide range of subjects falling within its mandate, including discriminatory legislation and practices with regard to marital status, nationality, allegations of abuses of women human rights defenders and violations of their rights, gender-based violence and rights to reproductive and sexual health (see A/HRC/30/27, A/HRC/31/79 and A/HRC/32/53). The Working Group also issued press releases, individually or jointly with other mandate holders, treaty bodies and regional mechanisms.

D. Other activities

8. On 15 June 2015, a member of the Working Group participated in a panel discussion on making social policy work for women at a workshop titled "Substantive equality for women: connecting human rights and public policy" organized by the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), the United Nations Institute for Social Development and OHCHR.

9. The Working Group, jointly with several special procedures, sent an open letter to the President of the Human Rights Council on 3 July 2015, in which it emphasized the importance of placing women's right to equality at the centre of discussions in the Council on the protection of the family.

10. A member of the Working Group participated as a panellist in an OHCHR global seminar on the human rights of migrant domestic workers in an irregular situation, titled "Behind closed doors", held on 28 and 29 September 2015 in Bangkok.

11. A member of the Working Group gave a presentation at the expert consultation on gender perspectives on torture and other cruel, inhuman or degrading treatment or punishment organized on 5 and 6 November 2015 by the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment.

III. Thematic analysis: eliminating discrimination against women with regard to health and safety[1]

A. Conceptual framework

12. The present report aims to clarify the meaning of equality in the area of health and safety, identify discriminatory practices, expose the instrumentalization of women's bodies in violation of their human dignity and reveal the barriers to women's autonomous, effective and affordable access to health care. Instrumentalization is defined as the subjection of women's natural biological functions to a politicized patriarchal agenda, which aims at maintaining and perpetrating certain ideas of femininity versus masculinity or of women's subordinate role in society.

[1] The analysis contained in the present report has a minimal number of footnotes owing to word limit restrictions. A version of the report with full references can be found at www.ohchr.org/EN/Issues/Women/WGWomen/Pages/WGWomenIndex.aspx. The report relies on WHO and UNAIDS sources for health data and draws upon the work of OHCHR and international human rights mechanisms, including the Committee on the Elimination of Discrimination against Women and the special procedures mandates on health, persons with disabilities, food, older persons, water and sanitation, and indigenous peoples.

13. Women's rights to equality and to the highest attainable standards of health, to enjoy the benefits of scientific progress and to health-care services, including those related to reproductive and sexual health, are enshrined in international and regional human rights instruments, reaffirmed in consensus agreements, including the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action adopted at the Fourth World Conference on Women and the outcome documents of the review and appraisal conferences, and recognized by international, regional and national mechanisms and jurisprudence. The International Conference on Population and Development, held in 1994, recognized women's rights to reproductive and sexual health as being key to women's health. Discrimination against women in the area of health and safety and denial of their right to control their own bodies severely violate their human dignity, which, along with equality, is recognized in the Universal Declaration of Human Rights as the foundation of freedom, justice and peace in the world.

14. States are obliged to secure women's rights to the highest attainable standard of health and safety, including their underlying determinants, and women's equal access to health-care services, including those related to family planning, as well as their rights to privacy, information and bodily integrity. The obligation to respect, protect and fulfil women's right to equal access to health-care services and to eliminate all forms of discrimination against women with regard to their health and safety is violated by neglecting women's health needs, failing to make gender-sensitive health interventions, depriving women of autonomous decision-making capacity and criminalizing or denying them access to health services that only women require. In some situations, failure to protect women's rights to health and safety may amount to cruel, inhuman or degrading treatment or punishment or torture, or even a violation of their right to life.

15. WHO defines health as not merely the absence of disease or infirmity, but as a state of complete physical, mental and social well-being. In the present report the Working Group addresses women's safety as an integral aspect of their health. Women's exposure to gender-based violence in both the public and private spheres, including in conflict situations, is a major component of women's physical and mental ill health and the destruction of their well-being, and constitutes a violation of their human rights.

16. Substantive equality in the area of health and safety requires differential treatment. Throughout their life cycle from childhood to old age, women have health needs and vulnerabilities that are distinctively different from those of men. Women have specific biological functions, are exposed to health problems that affect only women, are victims of pervasive gender-based violence and, statistically speaking, live longer than men, resulting in their greater need to access health services frequently and into older age. Hence, women and girls experience the negative effects of insufficiencies in health-care services more intensively than men.

17. Women face a disproportionate risk of being subjected to humiliating and degrading treatment in health-care facilities, especially during pregnancy, childbirth and the post-partum period. Furthermore, they are especially vulnerable to degrading treatment in situations where they are deprived of liberty, including in migrant detention facilities or mental institutions. They are subjected to humiliating treatment within the health-care system because of their gender identity and sexual orientation, sometimes expressly in the name of morality or religion, as a way of punishing what is considered "immoral" behaviour.

18. Women's bodies are instrumentalized for cultural, political and economic purposes rooted in patriarchal traditions. Instrumentalization occurs within and beyond the health sector and is deeply embedded in multiple forms of social and political control over women. It aims at perpetuating taboos and stigmas concerning women's bodies and their traditional roles in society, especially in relation to their sexuality and to reproduction. As a

result, women face continuous challenges in accessing health care and in maintaining autonomous control in decision-making about their own bodies. Understanding and eliminating the instrumentalization of women's bodies, which is based on harmful cultural norms and stereotypes, and its detrimental impact on women's health, is critical for change to occur.

19. A wide range of actors, both public and private, play a role that affects women's health and access to health care and each of the actors bears responsibility for its actions or inactions. In particular, the significant role of the principles enshrined in the deontological codes of different medical professionals and in the rules governing the corporate social responsibility of the pharmaceutical industry are an essential locus for establishing gender-sensitive research, medicines and treatments.

20. The State is accountable for fulfilling its international human rights obligation to ensure that women are provided with gender-responsive scientific research, medicines and health interventions and for providing appropriate and adequate gender-based resources and a system of effective monitoring, budgeting, remedies and redress. It is also obligated to provide women with autonomous, effective and affordable access to health care. The State has a responsibility to ensure that barriers to women's enjoyment of the right to the highest attainable standard of physical and mental health are dismantled, including by exercising due diligence.

21. A number of other factors and developments which have serious implications for women's health and safety are not tackled in the present report owing to space restrictions. These include climate change and other environmental catastrophes and degradation and gender-based violence in armed conflicts.

B. Meaning of equality in women's health and safety

22. In the area of health, the distinctly different biological and reproductive functions of women and men necessitate differential treatment and proper algorithms are required to make sure that women have equal access to and enjoy the highest achievable level of health treatment. An identical approach to treatment, medication, budgeting and accessibility would in fact constitute discrimination.

23. Central among women's and girls' health needs are those relating to their reproductive and sexual health. Substantive equality requires that States attend to the risk factors that predominantly affect women. For instance, since only women can become pregnant, a lack of access to contraceptives is bound to affect their health disproportionately. Equality in reproductive health requires access, without discrimination, to affordable, quality contraception; maternal health care, including during childbirth and the post-partum period; access to safe termination of pregnancy; access to effective screening and early treatment for breast and cervical cancer; and special attention to the high rate of HIV infections among young women and treatment to prevent mother-to-infant transmission.

24. Equality also requires health policy to be based solely on women's health needs and not to be influenced by instrumentalization and politicization. Political contestation around rights to reproductive and sexual health remains a global challenge, resulting in women paying a high price in terms of their health and lives. In adopting the 2030 Agenda for Sustainable Development, States committed to ensuring universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes. A strong commitment to women's sexual and reproductive rights in international and national law,

policies and programmes is crucial for achieving gender equality and ensuring women's and girl's right to health and well-being.

25. Many drug therapy protocols and other medical treatments and interventions administered to women are based on research conducted on the male of the species without any investigation and adjustment for biological and gender differences. Equality requires the conduct of medical research on the basis of women's experience and biological differences. It also requires adequate attention to be paid to the particular health risks to which women are disproportionately exposed, such as depression and suicide, and proper gender-sensitive treatment of diseases which tend to be considered, inaccurately, as typically masculine, such as cardiovascular diseases.

26. Women's specific health and safety needs require protection against gender-based violence that affects their physical integrity and mental health, including in health-care settings.

27. The social, religious and cultural factors that disregard the dignity of girls and women must be tackled to achieve women's right to equality in health and safety.

C. Discriminatory practices

28. Discriminatory practices in the area of health and safety occur at all stages of women's life cycle. Multiple discrimination merits particular consideration and remedies. Denying women access to services which only they require and failing to address their specific health and safety, including their reproductive and sexual health needs, are inherently discriminatory and prevent women from exercising control over their own bodies and lives. Gender-based discrimination in the administration of medical services also violates women's human rights and dignity.

29. Denial of access to essential health services with respect to termination of pregnancy, contraception, treatment for sexually transmitted diseases and infertility treatment has particularly serious consequences for women's health and lives. Women may be denied such services through criminalization, reduction of availability, stigmatization, deterrence or derogatory attitudes of health-care professionals. In reality, denial of access drives service provision underground into the hands of unqualified practitioners. This exacerbates the risks to the health and safety of the affected women. Persistently high maternal mortality rates often reflect a lack of investment in and underprioritization of services required only by women

30. Discrimination is sometimes manifested in humiliating treatment women that may face in facilities that are dedicated exclusively to them, such as birthing facilities where, as repeatedly stressed by United Nations human rights mechanisms and WHO, they are too often subjected to degrading and sometimes violent treatment.

31. Discrimination against women is also manifest in the unequal provision of health services required by both women and men. This has been especially severe in countries where women have been excluded from receiving medical treatment by male doctors on the grounds of "modesty".

32. Discriminatory laws and practices have contributed to a deplorable global situation with respect to women's health and safety which calls for urgent, immediate and effective actions. According to WHO, an estimated 225 million women are deprived of access to essential modern contraception. Pregnancy and childbirth-related complications resulted in the deaths of almost 300,000 women worldwide in 2013. About 22 million unsafe abortions take place annually and an estimated 47,000 women die from complications resulting from unsafe abortion each year. Breast and cervical cancer remain the leading cancers among

women aged 20-59 years, resulting in 1 million deaths, the majority in low- and middle-income countries where screening, prevention and treatment are almost non-existent. Young women bear the brunt of new HIV infections. One in three women under 50 has experienced physical and/or sexual violence by an intimate partner or family member. At least 200 million women and girls have been subjected to female genital mutilation.

1. Discrimination throughout a woman's life cycle

33. The Working Group notes with concern that issues relating to women's health are not addressed in a holistic manner on political and health agendas at the national and international levels. Policies regarding women's health services are often limited to questions of "maternal health". Despite the importance of prioritizing this issue, such a restrictive focus fails to recognize the full spectrum of women's rights to sexual and reproductive health at all stages of their life cycle and contributes to the instrumentalization of women's bodies, viewing them mainly as a means of reproduction.

34. Many girls are exposed to a wide variety of practices which are harmful to their health and well-being, such as female genital mutilation, discrimination in food allocation resulting in malnutrition and discrimination in access to professional health care. Furthermore, early marriage and adolescent pregnancy have a long-lasting impact on girls' physical integrity and mental health. Pregnancy and childbirth are together the second leading cause of death among 15- to 19-year-old girls globally, putting them at the highest risk of dying or suffering serious lifelong injuries as a result of pregnancy. For example, up to 65 per cent of women with obstetric fistula, which is a severely disabling condition and often results in social exclusion, develop this condition as adolescents.

35. Adolescent girls are particularly exposed to gender-based violence in the family and on their way to or at school, with extremely harmful impacts on their physical and mental health. In its resolution 70/137 the General Assembly called upon all States to improve the safety of girls on the way to and from school, taking steps to ensure that all schools are accessible, safe, secure and free from violence and providing separate and adequate sanitation facilities that provide privacy and dignity.

36. In some countries, adolescent girls are deterred from accessing information and services for family planning and termination of pregnancy that are needed to protect their health and safety and prevent unwanted high-risk pregnancies, including the requirement of third party authorization.

37. During pregnancy, many women are vulnerable to malnutrition owing to discrimination in the allocation of food. This can result in a serious and irreversible deterioration of women's general health and increase the risk of premature delivery, low birth weight and birth defects. After childbirth, such discrimination can continue to affect women's health, including in connection with breastfeeding. Furthermore, as stated by the Special Rapporteur on the right to food, structural violence is an underexamined barrier to women's right to adequate food and nutrition. Gender-based violence, which is a primary form of discrimination, can impede women from accessing adequate food and nutrition.

38. Delays in seeking appropriate medical care, in reaching an appropriate health facility and in receiving appropriate care once at a facility, along with the lack of accessible maternal health care, are the main reasons behind high rates of maternal mortality and morbidity. A human rights-based approach that provides a functioning health system with adequate supplies, equipment and infrastructure as well as an efficient system of communication, referral and transport are therefore essential to eliminate these preventable deaths and to ensure women's rights to health and life.

39. Women's mental health during pregnancy, childbirth and the post-partum period requires both stability in their environment and emotional support. Reports of disrespect

and ill treatment during childbirth in health facilities in many countries provide a deeply distressing picture of the extent of women's exposure to degrading treatment, lack of privacy, and even verbal and physical violence. Pregnant women are sometimes refused pain relief during labour or anaesthesia during a termination of pregnancy by curettage. The use in some countries of custodial or punitive rather than educative measures to prevent injury to the fetus as result of drug or alcohol consumption by addicted pregnant women is another manifestation of gender discrimination.

40. Women have a longer life expectancy and are particularly exposed to neglect and abuse in older age, including in health-care settings, and higher risks of diseases such as Alzheimer's disease and other forms of dementia. A gender- and age-sensitive approach needs to take into account the specific needs for care and protection of older women, including those widowed, living alone or displaced, those with dementia or other disability, those in need of palliative and geriatric care and those in emergency situations; these women are most at risk of multiple forms of discrimination, violence and poverty.

41. In addition, problems associated with ageing affect women disproportionally as a result of the cumulative effect of discriminatory practices women face over the course of their lives, as the Working Group described in its report on discrimination against women in economic and social life (A/HRC/26/39). Women are more likely to take care of men and to be left without spousal support. At the same time, they are more likely to suffer economic disadvantages, exacerbated by discriminatory pension systems that fail to produce equal outcomes for women, and to be excluded from social security and health insurance schemes. They are thus at greater risk of living in poverty. The mere recognition of equal rights for all, without distinction, is thus insufficient to ensure in practice the enjoyment by older women of all human rights, including the right to health.

2. Women facing multiple and intersecting forms of discrimination

42. Recognizing and addressing the nature and consequences of multiple and intersectional discrimination against women in national laws and practices is essential for protecting women's health and safety. Factors such as socioeconomic, minority and ethnic status, religion, race, sexual orientation, gender identity and expression, disability and bodily diversity exacerbate the discrimination that women face and infringe upon their ability to protect their health and safety.

Women and poverty

43. The Working Group is particularly concerned about the discrimination experienced by women because of their economic status. It has witnessed first-hand during its country visits that women living in poverty are disparately affected in their access to health services, particularly reproductive and sexual health and preventive health care.

44. There is growing concern about the feminization of poverty and the disparate impact of global economic crises, austerity measures and climate change on women's health and safety. Gender inequality persists in all regions, and women and girls continue to be overrepresented among the world's population living in poverty. Women and girls, particularly those living in the global South, are disproportionately burdened by the costs of these rapid changes, to the detriment of their personal health and well-being.

Women with disabilities

45. Women with disabilities face particular barriers in accessing health care for reasons of cost, distance, discriminatory attitudes, and lack of physical access or information. This seriously limits their access to immunization, reproductive health care and cancer screening. In some settings women with disabilities, particularly intellectual disabilities, are

subjected to forced sterilization or termination of pregnancy or to long-term contraception, with relatives or doctors taking decisions on their behalf without their informed consent, in violation of their right to exercise legal capacity guaranteed under the Convention on the Rights of Persons with Disabilities.

46. Women with disabilities are disproportionately subject to intimate-partner violence, owing to the mutually reinforcing dynamics of gender and disability.

47. The Special Rapporteur on the rights of persons with disabilities has called on States to guarantee women with disabilities safe participation in matters affecting their lives, especially in relation to sexual and reproductive rights and gender-based violence, including sexual violence, matters which are cited in a recent study as high-priority concerns for women and girls with disabilities.

Women and HIV/AIDS

48. Women are disproportionately vulnerable to HIV/AIDS owing to various factors, including gender-based violence and lack of autonomy to negotiate safe and responsible sexual practices and make informed health-related decisions. Even when women living with HIV/AIDS are able to access health services, they often face stigma and discrimination on the part of health-care professionals, ranging from abuse to denial of services. Laws, policies and practices that prevent women living with HIV from bearing children through, for example, forced termination of pregnancy and forced sterilization constitute an extreme form of discrimination.

Women migrants

49. Women migrants are often at great risk of being subjected by public authorities or private individuals to all manner of violence, exploitation, trafficking and slavery while in transit or in detention. These practices can amount to cruel, inhuman or degrading treatment or torture.

50. Women migrant workers, especially those in irregular situations, have greater difficulty in accessing almost all forms of health care, including maternal care, emergency care and treatment for chronic diseases and mental health problems, because they are often denied these rights legally and/or they fear arrest and deportation. In some countries, while legal access to health care for migrant women has been expanded, they still do not receive needed medical services because health-care providers often refuse treat them.

51. Even where they are entitled to emergency health care, women migrant domestic workers are often excluded from preventive reproductive and sexual health services, as well as gynaecological and obstetric care, because of their status and lack of access to insurance or national health schemes.

52. The pattern of physical, sexual and psychological abuse of migrant domestic workers is widespread. These women are often exposed to health and safety risks without being provided with proper information or adequate protection. Furthermore, the working and living conditions of many undocumented domestic workers, which are tantamount to slavery, and the separation from family members cause serious health, particularly mental health, problems.

53. Migrant women may be subject to mandatory pregnancy tests upon arrival in some countries; if the test is positive, they are dismissed and/or deported. Furthermore, pregnancy tests can be imposed on migrant domestic workers during the course of their employment, leading to pregnant women losing their jobs and/or seeking termination of the pregnancy, sometimes by means of unsafe practices, especially in countries that criminalize induced termination. Migrant women have been charged with "illegal sexual relationships" when

they become pregnant, including following rape. They are held in detention centres in deplorable conditions pending their deportation, or face severe punishment, including the death penalty in countries where sexual relationships outside marriage are criminalized.

Indigenous women

54. Indigenous women experience a complex spectrum of mutually reinforcing human rights abuses which is influenced by intersecting forms of discrimination and marginalization, reinforced by patriarchal power structures and past and present forms of violations of the right to self-determination and control of resources. These intersecting forms of discrimination have profound health consequences for indigenous women, especially for their reproductive and sexual health. The Special Rapporteur on the rights of indigenous peoples has reported (see A/HRC/30/41) about the barriers to reproductive and sexual health services encountered by indigenous women as well as past and recurrent human rights violations in relation to their sexual and reproductive rights. For example, indigenous women experience disproportionately higher levels of maternal mortality, indigenous girls are overrepresented among pregnant teenagers and indigenous women have lower rates of contraceptive use and higher rates of sexually transmitted diseases, including HIV/AIDS. Historically, there have also been instances of serious violations of indigenous women's rights to reproductive health in the context of the denial of the rights of indigenous peoples to self-determination and cultural autonomy. Those violations include forced sterilization of indigenous women and attempts to force them to have children with non-indigenous men as part of policies of cultural assimilation. Indigenous women may also face barriers to preventive care services that support their right to health, such as screening for ovarian and breast cancer.

55. The deplorable health outcomes for indigenous women are linked to decades of oppression and human rights violations against indigenous peoples, and against indigenous women in particular. Furthermore, non-indigenous health systems generally do not take into account the indigenous concept of health and health care, thereby creating barriers to access by indigenous women. Data usually fail to capture information on indigenous communities, rendering them "invisible". Even when such information exists, it is generally not disaggregated by sex. Additionally, indigenous women are disproportionately affected by illness owing to reduced coping capacity caused by the denial of other human rights and by extreme poverty.

Rural women

56. Rural women are particularly affected by patriarchal gender stereotypes and roles and are extremely vulnerable to harmful practices such as early or forced marriage and female genital mutilation, as well as to violence and poverty. These practices have a negative impact on their right to health. Rural women are usually particularly disadvantaged in accessing health-care services, including reproductive and sexual health services.

Minority women

57. As highlighted by the Special Rapporteur on minority issues (A/HRC/31/56), minority women, including women affected by discrimination based on caste, are particularly vulnerable to violations of their right to health, including reproductive and sexual health. Women members of "lower caste" groups present the worst health outcomes, especially in terms of life expectancy, access to maternal care, nutrition and incidence of infections. Roma women are the subjects of degrading stereotypes, depicted as "fertile" and "promiscuous"; this increases their vulnerability to gender-based violence and forced sterilization.

Women's sexual orientation and gender identity

58. In many settings, especially where same-sex consensual sexual behaviour is prohibited, lesbian, bisexual and transgender persons are deterred from seeking health services out of fear of being arrested and prosecuted. Even in countries where same-sex sexual orientation is not criminalized, lesbians are often discriminated against and mistreated by medical providers, which deters them from seeking health services. In some settings, they are subjected to coercive, inhumane and degrading practices such as "corrective" or punitive rape. Transgender persons are often subjected in law and practice to compulsory medical interventions without being given an opportunity for informed decision-making and choice. Their gender identity is pathologized in many countries and they are often subjected to mental and physical examinations and treatments and forced to undergo "conversion therapies". Transgender persons' biological needs, such as transition-related medical services, screening for cervical cancer, termination of pregnancy and contraception, are often refused by service providers.

Women deprived of liberty

59. Women in detention have specific health needs, particularly in terms of mental and reproductive health care, that are often neglected. Preventive services related to cervical and breast cancer are often unavailable and antiretroviral therapy, even for pregnant women living with HIV/AIDS, is completely absent in some facilities. The lack of adequate access to hygiene facilities and products for women prisoners is a typical and crucial concern in all regions of the world, jeopardizing the dignity and health of women prisoners. Practices such as shackling pregnant inmates during labour still occur in some countries. Detained women also face violence, including sexual violence from other prisoners or by staff.

60. Women prisoners show high rates of mental health problems owing to violence and trauma to which they had been exposed and which are exacerbated by imprisonment. Concerns about their children also have a significant impact on the mental health of women prisoners, especially when they are breastfeeding; separation from their children creates anxiety and guilt, resulting in great suffering. Women are more likely to harm themselves or attempt suicide while in detention than men. Extensive reliance on preventive use of psychotropic medication for "safety" reasons in such situations is an example of overmedicalization.

D. Instrumentalization of women's bodies

61. Throughout their life cycle, women's bodies are instrumentalized and their biological functions and needs are stigmatized and subjected to a politicized patriarchal agenda. States have also often treated women instrumentally as tools with which to implement population programmes and policies. This is sometimes carried out through the use of criminal sanctions and often under the guise of protecting women's health and safety and with cultural or religious justifications.

62. Much of the discrimination in access to health services and the resulting preventable ill health of women, including maternal mortality and morbidity and infertility, can be attributed to the instrumentalization of women's bodies for political, cultural, religious and economic purposes.

1. Negation of autonomy

63. The instrumentalization of women's bodies may result in conditioning women's access to medical assistance on the consent of a spouse or male guardian, causing withholding or delay of treatment, curtailment of women's autonomy and denial of respect

for privacy and obstructing their access to health care, particularly reproductive and sexual health care. Patriarchal negation of women's autonomy in decision-making leads to violation of women's rights to health, privacy, reproductive and sexual self-determination, physical integrity and even to life.

2. Effects of son preference

64. In patriarchal cultures, the preference for sons leads to the prioritization of boys' and men's health before that of women and girls, resulting in discriminatory practices such as female infanticide. This is evident in cultural customs relating to food which cause girls and women, including pregnant and nursing women, to suffer disproportionately from malnutrition.

3. Harmful gender stereotypes

Objectification of women

65. The instrumentalization of women's bodies as objects to serve sexual and other purposes leads to practices such as invasive cosmetic procedures. Unhealthy dieting, particularly among adolescent girls, can have disastrous health consequences, including eating disorders such as anorexia and bulimia.

66. According to WHO, a body mass index under 16 represents severe thinness. Setting minimum standards of weight for fashion models in line with health guidance via national legislation and policies and/or regulations by modelling agencies as well as advertising campaigns embracing the diversity of female forms are good practices. The development of new models of dolls with body proportions corresponding to those of healthy women is another.

Stigmatization of women's health

67. Stigma is a deeply entrenched social and cultural phenomenon which lies at the root of many human rights violations and results in entire population groups being disadvantaged and excluded, as the Special Rapporteur on the right to water and sanitation has noted (A/HRC/30/39). Women are exposed to harmful gender stereotypes or taboos regarding natural and biological functions such as menstruation, breastfeeding and menopause. Diagnosis of mental illnesses in women is biased so as to stigmatize them and has been used as a justification for institutionalizing women unnecessarily against their will.

68. Menstruation is surrounded by stigma, resulting in the ostracism of and discrimination against women and girls. In some cultures menstruating women and girls are considered to be contaminated and impure and restrictions and interdictions during menstruation are imposed on them. Women and girls may continue to harbour internalized stigma and are embarrassed to discuss menstruation even where there are no restrictions. They live with a lack of privacy for cleaning and washing, a fear of staining and smelling and a lack of hygiene in school toilets or separate sanitation facilities.

69. Furthermore, many girls do not receive sexuality education, including knowledge about the functioning of their bodies, and hygienic materials for menstruation are either unavailable or too costly. They are forced to use improvised, unhygienic materials that may lead to leaking and infections.

70. The stigma and shame generated by stereotypes around menstruation have severe impacts on all aspects of women's and girls' lives, on their dignity and well-being as well as on their right to education and to employment, as they may feel obliged to stay home from school or work every month because of appropriate facilities and hygienic items are

not available. Characterizing women's menstrual pain as "neurotic" tends to make women reluctant to seek help, which can delay diagnosis of, for example, the severely disabling disease of endometriosis, in which tissue that normally grows inside the uterus grows in an abnormal anatomical location.

71. Prejudices surrounding menopause may affect women's confidence in professional and public life, owing to age-based discrimination in the workplace. In some societies, this question is poorly addressed and understood, if at all. Medicalization through hormone replacement therapy, and pressure on active women to use it, even where there are health contraindications, can have a detrimental effect on women's mental health.

72. Similarly, instrumentalization and stigmatization are at work regarding breastfeeding in public spaces and at workplaces. Aside from the fact that breastfeeding is often promoted or discouraged for economic reasons, it may be viewed as inappropriate even in countries where the practice is legally protected, exposing women to unnecessary stress and pressure from intimidation and harassment. According to the United Nations Children's Fund (UNICEF), the majority of the approximately 830 million women workers worldwide do not enjoy workplace policies that support nursing mothers.

4. Pathologization and overmedicalization of women

73. Viewing women's behaviour and biological physiology, in particular their reproductive functions and sexuality, as symptomatic of medical problems reflects a history of gendered pathologization. Historically, pathologization, unnecessary medicalization and institutionalization in mental care facilities have functioned as forms of social control exercised by patriarchal establishments to preserve the gender roles of women. Pathologization of women's behaviour has been evidenced in psychiatric diagnoses, which often directly target perceived immoral activity such as unconventional sexual activity or intellectual independence as a source of mental illness or disorder.

74. The Working Group is concerned that many national laws and policies provide for overmedicalization of certain services that women need to preserve their health without a justified medical reason. These include requirements that only doctors can perform certain services, such as pharmaceutical termination of pregnancy or obstetric care. In many countries, women are not given a free choice between different ways of giving birth. Caesarian sections, when medically justified, can be crucial in preventing maternal and perinatal mortality and morbidity. However, studies conducted by WHO demonstrated that performing caesarian sections on more than 10 per cent of women does not lead to improvement in mortality rates. Caesarean section rates of 30 per cent in some countries demonstrate overmedicalization of childbirth, with the risks of obstetrical complications and health problems.

75. Overmedicalization may result in reduced access to or affordability of services needed by women and a barrier to developing adequate alternative services which can be competently provided by nurses, midwives or auxiliary nurses, either at clinics or at home. Such "task shifting", particularly in places where there are few qualified doctors, would make services more accessible. Similarly, restricting authorization for the use of contraceptives to a medical practitioner is a barrier to access. Allowing pharmacists to provide contraceptives, including emergency contraceptives, over the counter is essential for effective availability, especially for economically disadvantaged women or adolescent girls.

5. Discriminatory use of the criminal law

76. The discriminatory use of criminal law, punitive sanctions and legal restrictions to regulate women's control over their own bodies is a severe and unjustified form of State

control. This can include punitive provisions in criminal, civil and administrative laws and regulations governing extramarital consensual sex, same-sex consensual adult relations, gender non-conforming expressions, provision of reproductive and sexual education and information, termination of pregnancy and prostitution/sex work. The enforcement of such provisions generates stigma and discrimination and violates women's human rights. It infringes women's dignity and bodily integrity by restricting their autonomy to make decisions about their own lives and health.

77. States also violate women's right to health and safety where women are penalized for sexual or reproductive conduct that should not be criminally prohibited, such as adultery, prostitution or termination of pregnancy; States also violate the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment where they impose penalties such as stoning and lashing.

78. Criminalization of behaviour that is attributed only to women is discriminatory per se and generates and perpetuates stigma. The threat of criminal punishment restricts women's access to sexual and reproductive health-care services and information and acts as a deterrent to health-care professionals, thus barring women's and girls' access to health-care services.

Criminalizing and restricting the provision of and access to safe, legal services for termination of pregnancy

79. Criminalization of termination of pregnancy is one of the most damaging ways of instrumentalizing and politicizing women's bodies and lives, subjecting them to risks to their lives or health in order to preserve their function as reproductive agents and depriving them of autonomy in decision-making about their own bodies. Restrictive laws apply to 40 per cent of women worldwide. In some countries, as a result of retrogressive anti-abortion laws, women are imprisoned for having had a miscarriage, imposing an intolerable cost on the women, their families and their societies.

80. As demonstrated by WHO data, criminalizing termination of pregnancy does not reduce the need for it. Rather, it is likely to increase the number of women seeking clandestine and unsafe solutions. Countries in Northern Europe, where women gained the right to termination of pregnancy in the 1970s or 1980s and are provided with access to information and to all methods of contraception, have the lowest rates of termination of pregnancy. Ultimately, criminalization does grave harm to women's health and human rights by stigmatizing a safe and needed medical procedure. In countries where induced termination of pregnancy is restricted by law and/or otherwise unavailable, safe termination of pregnancy is a privilege of the rich, while women with limited resources have little choice but to resort to unsafe providers and practices. This results in severe discrimination against economically disadvantaged women, which the Working Group has highlighted during its country visits.

81. It is important to recall that the use of effective contraception can result in lowering the incidence of unintended pregnancy. However, contraception cannot eliminate women's need for access to termination of pregnancy, for example in the case of rape. In addition, no method of contraception is 100 per cent effective in preventing pregnancy.

82. In addition, restrictions on access to information on termination of pregnancy and services can deter women from seeking professional medical attention, with detrimental consequences for their health and safety. Examples of restrictions include criminalization of medical practitioners who provide these services; prohibiting access to information on legal termination of pregnancy; requiring third-party authorization from one or more medical professionals, a hospital committee, a parent, guardian or spouse; conscientious objection by health practitioners without provision of an alternative; requiring compulsory waiting

periods; and excluding coverage for termination of pregnancy services under health insurance. None of these requirements is justified on health grounds.

83. International and regional human rights bodies have called on States to decriminalize access to termination of pregnancy and to liberalize laws and policies in order to guarantee women's access to safe services. Treaty bodies, including the Committee on the Elimination of Discrimination against Women and the Committee on Economic, Social and Cultural Rights, have requested States, through their jurisprudence, their general comments/recommendations and their concluding observations, to review national legislation with a view to decriminalizing termination of pregnancy and to ensure a woman's right to termination of pregnancy where there is a threat to her life or health, or where the pregnancy is the result of rape or incest. The Committee against Torture and the Human Rights Committee have determined that, in some cases, being forced to carry an unwanted pregnancy to term amounts to cruel and inhuman treatment.

Criminalization of women who engage in prostitution/sex work

84. Criminal laws and other punitive regulations have imposed custodial sentences on women involved in prostitution/sex work in a manner that has been shown to harm rather than protect them. The Working Group considers that the criminalization of women in prostitution/sex work places them in a situation of injustice, vulnerability and stigma and is contrary to international human rights law. It notes that the Convention on the Elimination of All Forms of Discrimination against Women calls for prohibition of the exploitation of prostitution and not for punishment of the women in prostitution/sex work themselves; the well-established position of the Committee on the Elimination of Discrimination against Women that women should not be criminalized for prostitution; and the stipulation in the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime (Palermo Protocol) that efforts should be made to discourage the demand that fosters all forms of exploitation of women, including trafficking for sexual exploitation.

85. International organizations and human rights bodies have called on States to ensure, at a minimum, that women in prostitution/sex workers have the right to access sexual health services; are free from violence or discrimination, whether committed by State agents or private persons; and have access to equal protection of the law. In particular, States should also ensure that law enforcement officials serve a protective function, as opposed to engaging in or perpetuating violence against women in prostitution/sex workers. A number of States have introduced regulations that cover health and safety issues, including access to health services, medical insurance and social security benefits that have had a positive impact on women engaged in prostitution/sex work.

E. Autonomous, affordable and effective access to health care

1. Autonomous access

86. Autonomous access to health care means ensuring a woman's right to make decisions concerning her health, fertility and sexuality free of coercion and violence. Key to this is the notion of choice. The rights to informed consent and confidentiality are crucial to ensuring that women can make decisions freely. These rights impose corresponding duties upon health-care providers, who are bound to disclose information about proposed treatments and alternatives in order to aid informed consent and to respect the right to refuse treatment; likewise, they are bound to maintain confidentiality to allow women to make private decisions without the interference of others whom they have not chosen to consult and who might not have their best interests at heart. Autonomy means that a woman seeking services in relation to her health, fertility or sexuality is entitled to be treated as an

individual in her own right, the sole beneficiary of the service provided by the health-care practitioner and fully competent to make decisions concerning her own health. This is a matter of, among other things, a woman's right to equality before the law.

2. Affordable health care

87. Even where significant resources are being put in place to provide universal health care, women continue to have unequal access to good-quality health-care services in many countries. This is often because the health services that only women need are excluded from insurance coverage and are not affordable.

88. Economically disadvantaged women who do not have the means to access private health care and services are disparately affected by barriers created by unaffordability. It is therefore important for States to ensure that all health care is affordable and to remove legal restrictions that in effect discriminate against women who are economically disadvantaged.

89. Health care is often unaffordable owing to discriminatory health insurance coverage. Some health insurance policies and programmes exclude various aspects of reproductive health care, including modern forms of contraception, termination of pregnancy and maternal care. Alternatively, some private health insurance schemes insure women's reproductive health needs but add a surcharge to the premiums paid by women. Good practice includes measures that discourage insurance companies from charging women more for health insurance than men because of perceived higher costs associated with women's reproductive health needs.

90. Public funding is necessary to subsidize primary health-care services, including medications, contraceptives, legal termination of pregnancy and treatment of sexually transmitted infections. Such services should be affordable and, in the case of economically disadvantaged women, provided free of charge. User or "informal" fees for health-care services increase the risk that these women will either forgo services or resort to substandard services, perhaps from unqualified providers.

91. Good practices include listing as essential medicines all those recommended as necessary for women's health in the WHO Model List of Essential Medicines, public subsidization of the cost of women's health-related services for everyone and subsidies to women of a given age or income.

92. Unaffordability of medicines is also closely linked to intellectual property laws, many of which provide exclusive patents for new medicines for long periods. However, intellectual property laws that fail to address the medical needs of women obstruct access to medicines by pushing up the price and by impeding the production and distribution of low-cost generic drugs. The right to health requires States to ensure that the pharmaceutical companies that hold a patent on essential medicines and medical devices make use of all the arrangements at their disposal to render the medicines accessible to all.

3. Effective access

Conscientious objection to providing health services

93. Inadequately regulated conscientious objection may constitute a barrier for women when exercising their right to have access to reproductive and sexual health services. The jurisprudence of human rights treaty bodies states that where conscientious objection is permitted, States still have an obligation to ensure that women's access to reproductive health services is not limited and that conscientious objection is a personal, not an institutional, practice.

94. A number of countries have legal guarantees that protect women in the case of conscience-based refusal of care. They include the requirement of referral to non-objecting providers, registration/written notice to the employer and/or a government body, disclosure of information to patients about the provider's status as a conscientious objector, provision of services in cases of emergency, and restriction of the right to conscientious objection to the individuals directly involved in the medical intervention and not institutions or those indirectly involved, such as pharmacists. The Working Group reiterates that the enjoyment of the right to freedom of religion or belief cannot be used to justify gender discrimination and therefore should not be regarded as a justification for hindering the realization of women's right to the highest attainable standard of health.

Education and information

95. Restrictions in many countries on girls' and women's access to unbiased, quality education, including evidence-based comprehensive sexuality education, and information about where and how to obtain essential health services prevent women from making free and informed decisions about their health and safety and hence obstruct proper, informed access to health care. This is particularly true for adolescents and marginalized women facing multiple and intersectional forms of discrimination. Such restrictions are manifestations of censorship that limit women's and girls' choices.

96. States have an obligation to provide education, one of whose aims is to facilitate access to scientific and technical knowledge. This is of crucial importance with respect to questions of sexuality, reproduction and health education. States have an obligation to allow information about health matters to flow freely, without State interference on moral or other grounds. It also encompasses the possibility for non-State actors to disseminate information, including in relation to sexuality and sexual and reproductive health services. However, States also have an obligation to address and eliminate harmful and wrongful gender stereotypes that contribute to the violation of women's right to health and safety.

97. A growing number of States worldwide have confirmed their commitment to comprehensive sexuality education as an essential priority for achieving national development, health and education goals. In its resolution 70/137, the General Assembly called upon all States to develop and implement educational programmes and teaching materials, as well as teacher education and training programmes for both formal and non-formal education, including comprehensive evidence-based education on human sexuality, based on full and accurate information, for all adolescents and youth; to modify the social and cultural patterns of conduct of men and women of all ages; to eliminate prejudices; and to promote and build decision-making, communication and risk reduction skills for the development of respectful relationships based on gender equality and human rights.

IV. Conclusions and recommendations

98. In the context of women's and girls' health and safety, equality means the provision of differential services, treatment and medicines in accordance with their specific biological needs, throughout their life cycle. In many countries there is discriminatory exclusion and neglect of women in providing the highest attainable standard of health for women. Discrimination is particularly evident regarding women's right to reproductive and sexual health. It is exacerbated in the case of women members of marginalized groups. Discrimination against women and girls leading to the violation of their right to health and safety denies their right to human dignity.

99. The Working Group found that instrumentalization and politicization of women's biological functions in many countries subjects legislation and policies regarding women's and girls' health and safety to patriarchal agendas, especially regarding reproductive and sexual health and mental health. The Working Group found manifestations in all regions of instrumentalization, taboos regarding menstruation and breastfeeding and stereotypes which result in harmful practices such as female genital mutilation or which have a negative impact on women's body image, leading to their seeking invasive cosmetic procedures.

100. Women's access to health services in many countries is not autonomous, affordable and effective, elements which are essential for States to respect, protect and fulfil women's and girls' rights to life, health, privacy, equality and human dignity. A major barrier is lack of affordability as a result of exclusion from insurance for treatments specifically needed by women and girls or exclusion of groups of women such as migrants. Non-affordability severely discriminates against women living in poverty. Barriers also include restrictive legislative requirements, biased and stigmatized provision of services and conscientious objection to providing services.

101. Health services are provided by various actors, State and non-State. All actors have some form of responsibility for providing equal access for women to the highest attainable standard of health, including with regard to their reproductive and sexual health. The State has a due diligence obligation to ensure that private actors do not discriminate against women.

102. The result of the various forms of discrimination against women in the provision of health services is the costly and tragic phenomenon of women's preventable ill health.

A. General recommendations

103. The Working Group calls upon the Human Rights Council to urge States to take all necessary measures to respect, protect and fulfil women's right to the enjoyment of the highest attainable standards of health worldwide, including regarding their reproductive and sexual health, and to dedicate priority attention to a thorough stocktaking, including by convening an appropriate forum to tackle this crucial issue.

104. The Working Group calls upon all Member States to reaffirm and respect the commitments they made in Beijing and in Cairo and in the Sustainable Development Goals to implement the comprehensive provisions concerning women's health in the agreements they adopted and to develop national laws, policies and programmes within the framework of international human rights standards.

B. Equality and non-discrimination

105. The Working Group recommends that States:

(a) Apply human rights standards and principles of equality, non-discrimination and empowerment of women as the framework for all interventions regarding women's health and safety;

(b) Be guided by an understanding of women's right to equality, which requires differential treatment in health, including and beyond their sexual and reproductive health, in designing policy measures and resource allocations;

(c) Take into account the impact of women's safety on their physical and mental health and protect women and girls from violence at home, on their way to or at school and in other public spaces and in health facilities;

(d) Adopt a holistic approach towards women's health and safety by looking at their full life cycle from childhood to old age as interconnected phases with distinct considerations and needs, and in this regard:

(i) Take effective measures to prevent child marriage and adolescent pregnancies and provide girls with comprehensive education based on scientific evidence on matters of health, including sexuality;

(ii) Address the gender discrimination that exists in some cultures in the provision of food to the girl child, including through the empowerment of women and girls;

(iii) Allow pregnant girls and adolescents to terminate unwanted pregnancies, as a measure of equality and health, so that they can complete their school education and protect them from the high risk to life and health, including from obstetric fistula, in continuing to bring a pregnancy to term;

(iv) Reduce maternal mortality and morbidity by ensuring proper prenatal, birthing and post-natal care, including, where necessary, safe termination of pregnancy.

(v) Reduce the high incidence of maternal mortality among women with HIV/AIDS, both by preventing infection, particularly of women in prostitution/sex workers, and by free and secure provision of condoms and of antiretroviral treatment for pregnant women;

(vi) Provide adequate nutrition and free services for pregnant and lactating women, as required by the Committee on Economic, Social and Cultural Rights and the Committee on the Elimination of Discrimination against Women;

(vii) Ensure that laws, policies and practices mandate respect for women's autonomy in their decision-making, especially regarding pregnancy, birthing and postnatal care;

(viii) Provide gender- and age-sensitive health-care services for older women, taking cognizance of their heightened health and safety vulnerability;

(e) Provide special protection and support services to women facing multiple forms of discrimination, and in this regard:

(i) Ensure that health services, including reproductive and sexual health, for women with disabilities are available and accessible on an equal basis with others and that their autonomy and decision-making, including in relation to their sexuality and reproduction, are guaranteed in accordance with the principles of the Convention on the Rights of Persons with Disabilities;

(ii) Provide health-care coverage for migrant women and domestic workers, whose sexual and reproductive health, preventive health care and protection against gender-based violence are otherwise prejudiced;

(iii) Ensure social and health-care benefits, entitlements and protection to lesbians and bisexual and transgender persons without discrimination;

(iv) Provide access to preventive and remedial health services for women in prison, including in relation to cervical and breast cancer, contraception,

antiretroviral therapy and gender transition, and take all necessary measures to protect them from violence;

(v) Allow non-custodial sentences for pregnant women and women with dependent children in accordance with the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules).

C. Instrumentalization of women's bodies

106. The Working Group recommends that States:

(a) Take measures to combat and eliminate, in legislation and policies, cultural practices and social stereotypes, all forms of instrumentalization of women's bodies and biological functions;

(b) Eliminate harmful gender stereotypes, which could lead to anorexia and bulimia and invasive cosmetic procedures;

(c) Prevent exclusion from the public space during menstruation or breastfeeding and prevent discrimination in relation to menopause in the workplace;

(d) Take and implement strong and efficient measures to prevent female genital mutilation and other harmful practices;

(e) Decriminalize sexual and reproductive behaviours that are attributed exclusively or mainly to women, including adultery and prostitution, and termination of pregnancy;

(f) Combat stereotyping and empower girls to take care of their own health and safety from a young age, both at school and at home, and inform and empower women regarding their own bodies at all stages of their lives;

(g) Regulate birthing facilities to ensure respect for women's autonomy and privacy and human dignity, including respect for women's choice regarding home deliveries provided there are no specific medical contraindications;

(h) Prevent instrumentalization of women in the birthing process and ensure that penalties are incurred for gynaecological or obstetrical violence, including performing abusive caesarean sections, refusing to give women pain relief during birth or surgical termination of pregnancy and performing unnecessary episiotomies;

(i) Use educational and social work alternatives instead of custodial or punitive measures to prevent injury to the fetus as a result of drug or alcohol consumption by addicted pregnant women;

(j) Monitor and prevent the use of mental health to institutionalize women unnecessarily as a social control mechanism.

107. In relation to reproductive and sexual health care, the Working Group recommends that States:

(a) Abolish bans on contraception, including emergency contraceptives, and provide access to affordable modern contraceptives;

(b) Repeal restrictive laws and policies in relation to termination of pregnancy, especially in cases of risk to the life or health, including the mental health, of the pregnant woman, rape, incest and fatal impairment of the fetus, recognizing that such laws and policies in any case primarily affect women living in poverty in a highly discriminatory way;

(c) **Recognize women's right to be free from unwanted pregnancies and ensure access to affordable and effective family planning measures. Noting that many countries where women have the right to abortion on request supported by affordable and effective family planning measures have the lowest abortion rates in the world, States should allow women to terminate a pregnancy on request during the first trimester or later in the specific cases listed above;**

(d) **Discontinue the use of criminal law to punish woman for ending a pregnancy and provide women and girls with medical treatment for miscarriage and complications of unsafe termination of pregnancy;**

(e) **Eliminate discriminatory barriers to access to legal termination of pregnancy that not based on medical needs, such as waiting periods for implementation of the decision to terminate a pregnancy, authorization requirements for reproductive health clinics and staff, and unduly restrictive interpretations of legal grounds for termination of pregnancy.**

D. Autonomous, affordable and effective access to health care

108. **The Working Group recommends that States:**

(a) **Ensure that access to health care is autonomous, affordable and effective;**

(b) **Address underlying factors which negate women's autonomy in decision-making regarding their own lives, health or bodies, through education, provision of information and monitoring mechanisms to ensure that their autonomy is respected at all levels of the health-care system;**

(c) **Invalidate conditioning of women's and girls' access to health care on third-party authorization;**

(d) **Provide training to health providers, including on gender equality and non-discrimination, respect for women's rights and dignity and recognition of alternative medicine;**

(e) **Provide non-discriminatory health insurance coverage for women, without surcharges for coverage of their reproductive and sexual health;**

(f) **Include contraception of choice, preventive care and treatment for cervical and breast cancer, termination of pregnancy and maternity care in universal health care or subsidize provision of these treatments and medicines to ensure that they are affordable;**

(g) **Restrict conscientious objection to the direct provider of the medical intervention and allow conscientious objection only where an alternative can be found for the patient to access treatment within the time needed for performance of the procedure;**

(h) **Exercise due diligence to ensure that the diverse actors and corporate and individual health providers who provide health services or produce medications do so in a non-discriminatory way and establish guidelines for the equal treatment of women patients under their codes of conduct;**

(i) **Provide age-appropriate, comprehensive and inclusive sexuality education based on scientific evidence and human rights, for girls and boys, as part of the mandatory school programmes. Sexuality education should give particular attention to gender equality, sexuality, relationships, gender identity, including non-**

conforming gender identities, and responsible parenthood and sexual behaviour to prevent early pregnancies and sexually transmitted infections;

(j) Ensure that the standards contained in the present recommendations are observed and enforced by all health-care providers, public or private, and engage both women and men, as appropriate, in efforts to prevent discrimination, stereotyping and instrumentalization of women's bodies and biological functions.

United Nations A/HRC/32/44/Add.1

General Assembly

Distr.: General
7 April 2016
English
Original: French

Human Rights Council
Thirty-second session
Agenda item 3
Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Report of the Working Group on the issue of discrimination against women in law and in practice on its mission to Senegal

Note by the secretariat

The Working Group undertook a visit to Senegal from 7 to 17 April 2015. The present report describes the situation as it relates to gender equality and the human rights of women in Senegal and analyses the progress made and the challenges to be overcome in this area. It explores the legal, institutional and policy frameworks geared to promoting equality. It examines the extent of women's participation and empowerment in economic, social, political, public, family and cultural life, as well as their access to health care. The Working Group makes recommendations for ways in which to eliminate discrimination and promote equality.

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Report of the Working Group on the issue of discrimination against women in law and in practice on its mission to Senegal*, **

Contents

		Page
I.	Introduction	3
	A. The visit	3
	B. Context	3
II.	Legal, institutional and policy framework	4
	A. Legal framework	4
	B. Access to justice	7
	C. Institutional and policy framework	8
III.	Participation of women in family, cultural, economic, social, public and political life	9
	A. Family and cultural life	9
	B. Economic and social life	11
	C. Political and public life	14
IV.	Right to health and access to health care	15
	A. General context	15
	B. Sexual and reproductive health and rights	16
V.	Violence against women	18
	A. Sexual abuse of girls	18
	B. Female genital mutilation	18
	C. Women victims of multiple forms of discrimination	19
VI	Best practices	20
VII.	Conclusions and recommendations	20
	A. Conclusions	20
	B. Recommendations	21

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I. Introduction

A. The visit

1. At the invitation of the Government, the Chair of the Working Group travelled to Senegal from 7 to 17 April 2015. She met with various actors in Dakar, Yeumbeul, Pikine, Kaolack, Diourbel, Fandène and Thiès. The Working Group wishes to thank the Government for its support in organizing the visit and its cooperation throughout the mission.

2. In Dakar, the Chair met with representatives of various ministries,[1] members of the National Assembly and representatives of the Economic, Social and Environmental Council, the National Observatory on Gender Parity, the National Observatory of Places of Deprivation of Liberty, the National Human Rights Committee and the Chamber of Commerce and Industry. In Kaolack, the Chair met with the deputy prefect, municipal counsellors and representatives of the legal advice centre (*maison de justice*). In Diourbel, she met with the governor, the head of the departmental service for community development, the deputy mayor and the official responsible for decentralized cooperation. In Thiès, she met with the deputy governor and representatives of the inspection service of the Ministry of Education. In Yeumbeul, she met with the mayor and representatives of the community counselling centre.

3. During the visit, the Chair of the Working Group also met with representatives of United Nations entities and civil society organizations and associations that promote the rights of women and girls. She visited a legal aid clinic (*boutique du droit*) in the Dakar medina[2] and a number of health centres and production units.[3] The Working Group wishes to thank the team of the Office of the United Nations High Commissioner for Human Rights (OHCHR) country office in Dakar for the invaluable support it provided before and during the visit.

B. Context

4. Senegal, which is engaged in a process of strengthening its democracy, has a poverty rate of 46.7 per cent and continues to register a low Human Development Index. The latter has declined in recent years: Senegal ranked 170th out of 188 countries in 2015 and 154th out of 186 in 2013.[4] Despite the Government's efforts and those of its technical and financial partners, the country is characterized by sharp inequalities, in particular with regard to gender. According to the United Nations Development Programme (UNDP),[5] the Gender Equality Index of Senegal ranks it 118th out of 188 countries. Geographic

[1] Ministère des affaires étrangères et des Sénégalais de l'extérieur, Ministère de la femme, de la famille et de l'enfance, Ministère de la santé et de l'action sociale, Ministère de l'intérieur et de la sécurité publique (Direction générale de l'administration territoriale et Directrice générale de la police nationale), Ministère de l'éducation nationale, Ministère de l'enseignement supérieur et de la recherche, Ministère de la formation professionnelle, de l'apprentissage et de l'artisanat, Ministère de la justice, Ministère de l'économie, des finances et du plan, Ministère du commerce, du secteur informel et de la consommation, et Ministère du renouveau urbain, de l'habitat et du cadre de vie.

[2] Tenue par l'Association de juristes sénégalaises.

[3] Associations de femmes rurales à Fandène.

[4] PNUD, Rapports mondiaux sur le développement humain 2015 et 2013.

[5] Ibid., 2015.

disparities are also pronounced, and the poverty rate in some regions reaches as high as 76.6 per cent.[6] Human development indices are 33 to 40 per cent lower in rural areas than in urban areas.[7] In spite of the progress made, the literacy rate (52.9 per cent) remains low and shows significant disparities along gender lines: only 43.3 per cent of women are literate, while the figure for men is 64.4 per cent.[8]

5. Most of the Millennium Development Goals have not been achieved. The recent assessment of the implementation of the Goals intended to benefit women and girls revealed that obstacles still remain, in particular with regard to eliminating poverty among women, reducing maternal and infant mortality, preventing the feminization of HIV/AIDS and other diseases, as well as mobilizing sufficient resources for achieving the Goals and the objectives of the Beijing Platform for Action.

6. Senegal cannot aspire to development without the genuine and full participation of women. The unequal assignment of roles and responsibilities within the family, the overall division of labour and the reduced economic power of women exacerbate the growing feminization of poverty. The Working Group observed that the many legal but predominantly sociocultural constraints impede the achievement of gender equality.

II. Legal, institutional and policy framework

A. Legal framework

International and regional levels

7. Senegal has ratified, without reservation, almost all the international and regional human rights instruments and has reaffirmed its commitment to giving effect to the Convention on the Elimination of All Forms of Discrimination against Women by ratifying the Optional Protocol to the Convention in 2000. The Working Group nonetheless regrets that Senegal did not submit its periodic reports to the Committee on the Elimination of Discrimination against Women between 1994 and 2013 and encourages it to do so now. Senegal is also a party to all the instruments of the African Union, including the 2003 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), which it ratified in 2004. Senegal has also ratified all the fundamental conventions of the International Labour Organization (ILO); however, it has not ratified ILO Equality of Treatment (Social Security) Convention, 1962 (No. 118), ILO Maternity Protection Convention, 2000 (No. 183) and ILO Domestic Workers Convention, 2011 (No. 189).[9]

1. Achievements

National level

8. The Working Group commends Senegal on the efforts it has made to strengthen its legal framework for the promotion and protection of women's rights and gender equality.

[6] Rapport périodique sur la mise en œuvre de la Charte africaine des droits de l'homme et des peuples, 2013 (:www.achpr.org/files/sessions/56th/state-reports/3rd-2004-2013/senegal_state_report_fr.pdf).

[7] PNUD, Rapport sur le développement humain 2010.

[8] Agence nationale de la statistique et de la démographie (ANSD), « Enquête à l'écoute du Sénégal 2014 » (www.ansd.sn/ressources/publications/Rapport%20L2S%20consolide-preliminaire.pdf).

[9] Pour les Conventions no 183 et no 189, des projets de ratification ont été adoptés en Conseil des Ministres et doivent être adoptés par l'Assemblée nationale.

The Constitution reiterates the country's commitment to the Universal Declaration of Human Rights and the Convention on the Elimination of All Forms of Discrimination against Women. Article 1 of the Constitution stipulates that: "The Republic of Senegal is a secular, democratic and socially committed State." The Constitution safeguards the right to equality before the law for all individuals, irrespective of origin, race, sex or religion, and sets forth the principle of equality between men and women (art. 7). It also recognizes the right to education for all, equal access to land tenure and ownership (art. 15), the right of women to equal treatment under the law in matters of employment, wages and taxation (art. 25) and, after the amendment of article 7 in November 2007, equal access to elected and political office. Pursuant to article 98, all international instruments have primacy over domestic laws. The Working Group also welcomes the progress that has been made in the way of legislation.

9. Act No. 91-22 provides for free compulsory primary education, and Act No. 2004-37 makes education compulsory between the ages of 6 and 16.

10. Act No. 97-17 on the Labour Code establishes the right to equal pay for men and women and to paid maternity leave (see articles 9, 15, 17, 18 and 24 of the Social Security Code).

11. Act No. 99-05, which provides for the amendment of certain provisions of the Criminal Code, has been a key factor in combating violence against women by making the assault of a female person an aggravating circumstance; by penalizing sexual harassment, domestic violence, female genital mutilation, rape, sexual abuse of minors, incest and procuring; and by making family abandonment an offence enforceable against both spouses, rather than against women only, as it had previously stipulated.

12. Under Outline Act No. 2004-16 on Agriculture, Forestry and Livestock, the State is required to guarantee gender equality in rural areas, especially with regard to farming. The Act calls for measures that facilitate access to land and credit for women.

13. The Working Group also welcomes the adoption of Act No. 2005-18 on Reproductive Health, which safeguards a woman's right to make decisions about her reproductive health.[10]

14. The decrees of 23 November 2006, which provide for the amendment of the regulations governing civil servants and non-civil servants and the organization of health insurance institutions, respectively, give female employees the option of extending their social benefits to cover their husband and children. Pursuant to Act No. 2008-01 on Equal Taxation, women are now allowed to provide for their spouse and children, which they were previously prohibited from doing.

15. Act No. 2010-11 on Parity, which instituted full gender parity in all partially or totally elected offices, represented a significant step forward and propelled Senegal to the top of the subregion in terms of women's representation in parliament.

16. Under Act No. 2013-05 on Nationality, which provides for the amendment of Act No. 61-10 of 1961, Senegalese women are authorized to transfer their nationality to their children and husband, thereby removing flagrant discrimination in this area.

2. Challenges

17. The Family Code remains one of the chief sources of discrimination against women in Senegal and contains many discriminatory provisions,[11] such as those relating to the

[10] Voir par. 55 à 57.
[11] Voir par. 39 à 42.

choice of the conjugal home, which is the exclusive prerogative of the husband (art. 153); the minimum age of marriage, which is set at 16 for girls and 18 for boys (art. 111);[12] the exercise of parental authority by the father as the head of the family (art. 277); the persistence of the husband's "marital authority" over his wife (art. 152); and inequality in respect of inheritance (art. 637).

18. Article 116 of the Family Code recognizes polygamy as an institution under ordinary law by providing that, in the absence of a preclusion at the time of marriage or subsequently thereafter, a husband may simultaneously have four wives.[13]

19. Underage marriage is penalized only under civil law and by annulling the marriage; no criminal penalties are prescribed, except in the case in which a man enters into a marriage with a child under the age of 13 (article 300 of the Criminal Code).

20. Although the Social Security Code makes no distinction between men and women, article 21 on family allowances provides that allowances are to be granted to workers for each of their dependent children. In the case of a married couple, since the father is the sole holder of parental authority, he is the only one entitled to receive allowances (the amendment of article 277 of the Family Code could remedy this discriminatory rule).

21. General Order No. 54-52 of 1954 prohibits women from working at night in factories, mines, quarries, construction sites or workshops. Women may not, under any circumstances, work at outdoor store displays after 10 p.m. Although these provisions were originally intended to be protective in nature, they are nonetheless discriminatory. The Working Group laments the fact that there is no law that requires equal pay for equal work or a specific law on non-discrimination.[14]

22. The Working Group is concerned that existing legislation on violence does not cover marital rape, psychological violence or economic abuse and fails to provide for the imposition of protection orders against a violent husband, which would require his removal from the home, or for the establishment of a court specialized in cases of domestic violence. While Act No. 99-05 represents a significant step forward, there is still no comprehensive law on the prevention or elimination of gender-based violence that contains express provisions on prevention, better protection to women survivors of such violence, medical and psychosocial support for victims, the establishment of rehabilitation and economic empowerment projects or the punishment of the perpetrators of such violence. The existing legislation also fails to cover sexual harassment in schools and public places and considers rape to be an ordinary rather than serious offence (art. 320).

23. The Working Group is concerned at the fact that voluntary termination of pregnancy is prohibited under both the Criminal Code[15] and Act No. 2005-18 on Reproductive Health (art. 15) and carries a penalty of up to 5 years' imprisonment. Women may request a therapeutic abortion only if their life is at risk, and it is impossible for most women, especially those in rural areas, to meet the requirements set forth in the code of ethics, according to which three doctors must provide their opinion in assessing that risk.[16]

24. Although Senegal has pledged at both the international and regional levels to ensure full respect for women's rights, the incorporation into domestic law and enforcement of the

[12] Dans l'avant-projet de code de l'enfant, l'âge du mariage est fixé à 18 ans pour les filles et les garçons.

[13] Voir par. 42.

[14] Banque mondiale, *Women, Business and the Law 2016*. (http://wbl.worldbank.org/~/media/WBG/WBL/Documents/Reports/2016/Women-Business-and-the-Law-2016.pdf).

[15] Art. 305 et 305 *bis* hérités de l'époque coloniale.

[16] Voir par. 71 et 72.

instruments to which it is a party remain inadequate. The provisions of the new Constitution of 2001 that promote gender equality have yet to be implemented in practice.

B. Access to justice

25. Access to justice remains a major impediment to the full realization of women's rights. Most of the actors met with stressed the considerable difficulties that women face in seeking to access justice. Some senior officials even described it as an obstacle course. According to most of the actors, women are very distrustful, not only of the justice system but also of the police and the gendarmerie, despite the fact that some progress has been observed. Police officers admitted that there was a need to improve the treatment of women victims of violence in police and gendarmerie stations and to change the face of policing by recruiting more women.[17]

26. The Working Group observed that human rights training for justice officials, in particular in relation to women's rights, was neither standardized nor systematic. The Working Group underscores the need to properly train all relevant actors, starting with their basic training, and to further their knowledge by means of in-service training.

27. During the visit, the Working Group observed that access to justice is particularly problematic for women victims of violence. The fear of stigmatization and reprisals, the cost of proceedings, rural isolation, the difficulty of gathering the necessary evidence, the scarcity of women in the police force and the prevalence of inadequately trained staff members are all factors that prevent women from filing a complaint. When they do file a complaint, investigations are not always initiated. It is furthermore inadmissible that women should have to pay to obtain a medical certificate[18] in cases of sexual violence. When assailants are arrested and convicted, the dysfunctional nature of the justice system is such that offenders manage to get away without completing their sentences. The entire judicial system must come together to fight impunity. The Working Group welcomes the establishment of community counselling centres — a positive initiative that engages local communities in the prevention of violence — but is concerned by the tendency to resort to mediation in cases that should be referred to the criminal court.

28. Owing to serious shortcomings in the judicial system that persist despite efforts to provide access to justice at the local level through legal advice centres (*maisons de justice*), some associations have stepped in to offer free legal assistance to women as they complete the necessary formalities.[19] However, the Working Group regrets that associations cannot sue for damages in criminal proceedings and encourages the Government to adopt a provision in this regard as part of the reform of the Code of Criminal Procedure that was under way at the time of the visit.

29. The full realization of women's rights is significantly hampered by poor enforcement of existing legislation, sociocultural barriers and the lack of monitoring mechanisms to ensure that rights are respected. Lack of awareness of their rights is also a significant obstacle for women. The Working Group notes that there is a glaring need for the dissemination and popularization of laws, including in local languages.[20]

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[17] Selon les données partagées lors de la visite par la Direction générale de la police, il existe seulement 10 % de femmes dans le corps policier.

[18] De 5 000 à 10 000 francs CFA.

[19] Voir par. 85 ci-après.

[20] Le Groupe de travail salue en ce sens le lancement de la traduction de la Convention sur l'élimination de toutes les formes de discrimination à l'égard des femmes dans les six langues nationales le 25 janvier 2016.

C. Institutional and policy framework

1. Institutional framework

30. As part of its efforts to promote and protect women's rights and gender equality, Senegal has developed a number of institutional mechanisms that are responsible for implementing policy in this area. The Working Group welcomes the various initiatives undertaken by the Ministry of Women, the Family and Children, which conducts the policy on the promotion and protection of women's rights and efforts to combat discrimination against women. However, some of the stakeholders spoken to pointed to a lack of leadership and coordination within the Ministry. Other ministries and entities, such as the Ministry of Health and Welfare, the Ministry of Education, the Ministry of Vocational Training and the Economic, Social and Environmental Council also play a fundamental role.

31. The National Observatory on Gender Parity,[21] which was established in 2011, demonstrates the State's determination to strengthen the institutional apparatus for the promotion of gender equality. Its mandate is to monitor, assess and formulate proposals on the promotion of gender parity in public policies. The Working Group was disappointed to learn that the meager budget allocated to the Observatory did not enable it to fulfil its mandate. The Working Group encourages Senegal to strengthen the National Human Rights Committee with a view to bringing it into line with the Principles relating to the status of national institutions for the promotion and protection of human rights (Paris Principles) and strongly recommends the establishment within it of a subcommittee on women's rights.

32. The Working Group welcomes the establishment of gender units in the ministries but finds it regrettable that no specific additional budget has been allocated to them and that the civil servants working there have not all received the requisite training.

2. Policy implementation

33. The Working Group welcomes the measures taken by Senegal in key policy areas, such as education, training, health and social protection for vulnerable groups in order to tackle gender equality on various levels. These include the development of the Emerging Senegal Plan, the 2015 National Strategy on Gender Equality and the 2013-2017 National Strategy on Economic and Social Development. The Government has also supported the preparation of religious position papers that support gender equality.

34. For example, the general policy paper on the education and training sector for the period 2012-2025, through its Programme for the Improvement of Quality, Equity and Transparency, emphasizes the crucial importance of gender. A national project to increase the number of female teachers and researchers has been set up with the aim of improving girls' access to higher education and science programmes. In addition, programmes have been developed in the areas of literacy, vocational and technical training, girls' school enrolment and scholarships for girls specializing in scientific fields.[22] The 2013 National Child Protection Strategy also incorporates a gender perspective.

35. The participation of women in development policies has been one of the chief concerns of Senegal, as demonstrated by the many funds set up to this end: the Women's

[21] Autorité administrative indépendante, placée sous l'autorité du Président de la République, composée de représentants ministériels, parlementaires, politiques et de la société civile (http://onp.sn).

[22] Voir Ministère de l'éducation nationale, « Évaluation du Projet d'appui à l'éducation des filles (PAEF) », rapport final, avril 2013, et la « Situation nationale de l'éducation 2012 ».

Groups Support Fund for the purchase of equipment designed to lighten women's workload; the poverty reduction programme, which has allocated considerable funds to microcredit schemes benefiting primarily women; the National Fund for Women Entrepreneurs, which aims to curb the feminization of poverty and give renewed momentum to entrepreneurship through a progressive financing scheme and a new strategy on access to funding; and the National Credit Fund for Women, which finances projects for the most vulnerable groups of women.[23]

36. Major strides have been made in the health sector in recent years, including the introduction of universal health coverage, the preparation of the 2006-2015 multisectoral road map to speed up the reduction of maternal and neonatal mortality and morbidity, the development of health posts, the adoption of a law on HIV/AIDS, the geographical expansion of the capacity for performing caesarians, the programme on medical and financial support for women with obstetric fistula and many other initiatives launched by the Ministry of Health.[24]

37. The joint programme entitled "Eradication of Gender-based Violence and the Promotion of Human Rights" and the 2010-2015 National Action Plan to Hasten the End of the Practice of Excision exemplify the Government's commitment to fighting the scourge of gender-based violence. Other steps have been taken as well, such as the launch of a helpline (number 116) to receive reports and guide victims and the establishment of 15 counselling centres in 11 regions of the country.[25]

38. The Working Group observed that concerns regarding women's rights are not always taken into account in budgets at either the national or local level. The Working Group further observed that most of the actions undertaken are piecemeal, project oriented and often contingent upon donations from technical and financial partners, which does not systematically guarantee sustainable development for women. The Working Group notes that there are gaps in the formulation of effective strategies to coordinate and harmonize policies.[26]

III. Participation of women in family, cultural, economic, social, public and political life

A. Family and cultural life

39. As mentioned above (see para. 17), the Family Code is a source of serious discrimination against women that spreads to all aspects of their lives (work, education, health, safety, etc.) and prevents them from fully enjoying their rights. By establishing the husband's marital authority and assigning parental authority to fathers as the head of the family, the Code severely undermines women's prospects for development and empowerment, thereby affecting the joint management of the household and children. Prior

[23] Voir par. 51.

[24] Voir par. 64.

[25] Par ailleurs, selon les informations reçues, le Gouvernement encourage la participation des femmes au processus de négociation, de résolution et de maintien de la paix. Elles sont organisées en associations ou en réseau pour contribuer au processus de paix dans la partie sud du Sénégal à travers le programme de déminage de la Casamance naturelle et des activités de promotion de la paix. Diverses initiatives visent la réinsertion socioéconomique des femmes victimes de mines antipersonnel, le développement de programmes d'éducation aux risques causés par les mines et le soutien scolaire aux enfants des familles victimes.

[26] PNUD, Rapport mondial sur le développement humain 2005.

to recent legal reforms, only men could receive family allowances and provide for children. The fact that husbands are given the right to choose the conjugal home also poses a problem for wives, especially those who are salaried employees or are in polygamous marriages.

40. The Working Group is concerned that the Family Code sets the legal age of marriage at 16 for girls and 18 for boys. There is no criminal penalty for persons who allow an early marriage to be performed. The legal marriage age for girls should be raised to 18, and a new Criminal Code provision that penalizes early marriage should be adopted.

41. The issue of inheritance is problematic for Senegalese women on many levels. Under ordinary law, women are entitled to inherit on an equal basis with men, but the Islamic inheritance rules contained in article 637 of the Family Code entitle men to receive twice as much as women, which conflicts with the principle of equality enshrined in the Constitution.

42. In Senegal, 35.2 per cent[27] of registered marriages are polygamous[28] (see para. 18). Article 6 of the Maputo Protocol encourages monogamy as the preferred form of marriage.[29] The Working Group[30] shares the view of the Committee on the Elimination of Discrimination against Women and the Committee on the Rights of the Child to the effect that "polygamy is contrary to the dignity of women and girls and infringes on their human rights and freedoms, including equality and protection within the family".[31] The impact of polygamy includes harm to the physical and mental health and social well-being of wives, material harm and deprivation, as well as emotional and material harm to children, often with serious consequences for their welfare. States parties to the Convention on the Elimination of All Forms of Discrimination against Women have explicit obligations to discourage and prohibit polygamy because it is contrary to the Convention.[32] The Committee on the Elimination of Discrimination against Women also contends that polygamy has significant ramifications for the economic well-being of women and their children.[33] Studies have shown that polygamy actually often results in increased poverty in the family, especially in rural areas.[34]

43. Many actors emphasized difficulties in relation to the issuance of civil status documents,[35] especially marriage, birth[36] and death certificates. Divorce applications are often problematic, owing to the lack of a marriage certificate in cases of unregistered customary marriages. The required documents (such as the husband's identity card) can be difficult to obtain for a woman, particularly if she has been repudiated. Although

[27] Un chiffre qui ne tient pas compte des grands nombres de mariages coutumiers non constatés.

[28] www.ansd.sn/.

[29] www.achpr.org/fr/instruments/women-protocol/#5.

[30] Dans son rapport soumis au Conseil des droits de l'homme en juin 2015, le Groupe de travail a appelé à « la non-reconnaissance des mariages discriminatoires à l'égard des femmes et/ou qui n'assurent pas l'égalité et la justice aux femmes, quel que soit le système juridique, la religion, la coutume ou la tradition. Il s'agit, entre autres, des mariages précoces et/ou forcés, des mariages temporaires et de la polygamie » (A/HRC/29/40, par. 26).

[31] Recommandation générale/observation générale conjointe n° 31 du Comité pour l'élimination de la discrimination à l'égard des femmes et n° 18 du Comité des droits de l'enfant sur les pratiques préjudiciables (CEDAW/C/GC/31-CRC/C/GC/18), par. 25.

[32] CEDAW/C/GC/31/CRC/C/GC/18, par. 28. Voir aussi observations finales du Comité pour l'élimination de la discrimination à l'égard des femmes de juillet 2015 (CEDAW/C/SEN/CO/3-7).

[33] CEDAW/C/GC/31/CRC/C/GC/18, par. 28.

[34] Ibid., par. 26.

[35] Le Groupe de travail note un avant-projet de loi sur la modernisation de l'état civil.

[36] Certains agents de l'administration exigent la présence du père, et ce, sans aucun fondement juridique.

repudiation is considered under the law as a grievous insult that may constitute grounds for divorce, it does not, however, constitute a criminal offence.

44. Despite efforts to raise public awareness of the importance of registering children at birth and the organization of hearings by mobile units in order to increase the number of late registrations, the number of children without birth certificates remains very high.[37] This can cause serious difficulties throughout children's lives, in particular with regard to education, given that they cannot sit exams without a birth certificate, even at the primary level.

Women and the media

45. Many of the actors met with denounced the negative role played by some media, which reproduce and perpetuate stereotypes that are degrading to women and confine them to their role as submissive wives, mothers and mistresses of the house and to the performance of household chores. Although women's presence in the media has grown, their image appears to have deteriorated. In addition, many of the persons spoken to criticized the fact that only an elite few, who are not representative of the majority of Senegalese women, are given an opportunity to express themselves. It would also appear that some media are the instigators of propaganda against the promotion of women's rights and gender equality. There were reports that the media joined a campaign to oppose a bill on therapeutic abortion in cases of rape and incest or when a woman's life is at risk.

46. The Working Group encourages Senegal to continue to systematically include gender modules in journalism training programmes in order to counter the persistence of a culture that devalues the image of women in the media. It also encourages Senegal to increase the participation of women in broadcasts that are of national interest.

47. The traditional roles assigned to girls and women in the family and the unequal distribution of tasks have an adverse effect on every aspect of a woman's life and limit women's socioeconomic prospects and opportunities for empowerment.

B. Economic and social life

48. According to a World Bank report on women, business and the law, Senegal continues to considerably limit the economic activity of women.[38] Societal expectations of the role of women, unequal access to credit and limited education opportunities undermine women's participation in gainful and sustainable economic activity. Most active women in Senegal work in the informal economy and agriculture. Women spend a significant amount of time on domestic tasks (90 per cent of household chores are carried out by women[39]), which results in low income, unstable and sometimes dangerous working conditions and unpaid employment. Businesses run by women are found mostly in the processing of farm and fish products. The Working Group observed that poor working conditions prevent women from deriving optimum profit from their activities because of inefficient means of production and transformation, as well as limited training.

[37] Pour 2005-2012, 65,9 % en milieu rural, 89,3 % en milieu urbain des naissances ont été enregistrées à l'état civil (www.unicef.org/french/infobycountry/senegal_statistics.html).

[38] Banque mondiale, *Women, Business and the Law 2016*. (http://wbl.worldbank.org/~/media/WBG/WBL/Documents/Reports/2016/Women-Business-and-the-Law-2016.pdf).

[39] *La Citoyenne*, revue de l'Association des juristes sénégalaises, janvier 2015.

49. Women's rate of participation in the active population was 67 per cent in 2015[40] and has not increased appreciably over the past decade, as in 2002, it was 65.7 per cent.[41] The Working Group welcomes the initiatives that have been taken to develop kindergartens and community childcare centres[42] as a means of facilitating the inclusion of women in active life. However, these preschool facilities fail to meet demand: only 223,000 out of 1.6 million children who have applied are accepted.[43] In rural areas, less than 1 per cent of children from ages 3 to 5 have access to kindergarten, as compared to 6 per cent in urban areas.[44] The system of early childhood care and education in Senegal has severe shortcomings and is characterized by inadequate, unequally distributed facilities, which does little to further the economic participation of women.

50. Although women contribute in a significant, often hidden, way to the country's economy, they still earn substantially less than men. The average gross national income for a woman in 2014 was 1,642 dollars, as compared to 2,717 dollars for a man.[45] Unemployment is almost twice as high among women as it is among men (16.7 per cent and 9.5 per cent, respectively).[46] Some 83 per cent[47] of active women work in the informal sector where they are not entitled to basic social services, such as social security and health insurance, despite the fact that they work long hours in unsanitary and often unsafe conditions.

51. The Working Group finds it regrettable that only 34 per cent of State-granted microcredit loans are awarded to women and that the amount of these loans is as much as 20 per cent less than those awarded to men, despite the fact that women are better at reimbursing their loans (15 per cent of women default on their loans, as compared to 24 per cent of men).[48] The Working Group observed that these loans do not, however, guarantee the sustainability of women's economic activities. It is concerned at the lack of much-needed follow-up to assess the real impact of empowerment programmes, which appear, at first glance, to be poorly coordinated and not to provide a satisfactory solution for lifting women permanently out of poverty. Women's inadequate technical and managerial training, their limited access to flourishing and profitable markets and the low level of spending on projects and programmes for the benefit of women (less than 2 per cent of the national budget) narrow the prospects for women's full participation in the country's economic development and for overcoming their poverty. It is vital to find solutions that offer better guidance to women and increase their earning potential over the long term. The Working Group also finds it regrettable that only 7 per cent of businesses registered with the Dakar Chamber of Commerce are headed by women.[49] The majority of the owners of small and medium-sized enterprises are men (81.1 per cent).[50]

52. The Working Group is particularly concerned that women have very limited and unequal access to land. Although the Constitution provides for equal access to land, less

[40] Banque mondiale, *Women, Business and the Law 2016*.

[41] « En bref, l'autonomisation économique des femmes au Sénégal », ONU Femmes, 2014, et OIT, *Tendances mondiales de l'emploi des femmes 2012*, p. 15.

[42] « Les cases des tout-petits », modèle de politique de prise en charge de la petite enfance, mis en place depuis 2002.

[43] Information fournie par le Ministère de l'éducation nationale lors de la visite.

[44] PAQUET, 2013.

[45] PNUD, Rapport mondial sur le développement humain 2014.

[46] www.ansd.sn/ressources/publications/Resume_Resultats_ENES-2015.pdf.

[47] Rapport du Conseil économique, social et environnemental, « Droits de la femme, acquis, enjeux et perspectives », 2014.

[48] Information fournie par le Ministère des finances, de l'économie et du plan.

[49] Information fournie par la Chambre de commerce de Dakar.

[50] ANSD, Enquête nationale sur les PME (ENPME 2013).

than 2 per cent of women have access to land as the result of purchase, less than 15 per cent hold assigned plots and only 25 per cent have access through inheritance. Yet women carry out 70 per cent of farming activities and are responsible for more than 80 per cent of agricultural production, especially of food crops.[51] They also face limited access to the means of production. Societal norms that encourage granting the status of head of the holding to men, women's limited mobility and their relatively low income result in de facto discrimination in terms of access to the products of cultivated lands, but also in terms of the control and use of those lands.[52] The Working Group welcomes the land reform that is currently under way and hopes that quotas will be introduced in order to ensure equal access to land.

53. During its visit, the Working Group was informed of cases of violations of the rights of women domestic workers, who are often the victims of exploitation and sexual violence and are largely illiterate and marginalized. They do not have access to basic social services, work in poor conditions and are paid far less than the minimum wage.

Education

54. Senegal has made significant progress in recent years in terms of access to primary and secondary education. The Working Group notes with satisfaction that the country has reached gender parity in access to primary education. The gross enrolment rate of girls rose from 62.3 per cent in 2000 to 99.8 per cent in 2012, as compared with 71.9 per cent in 2000 and 88.9 per cent in 2012 for boys.[53] The rate of completion of primary education among girls has also risen, having increased from 40.2 per cent in 2002 to 63.1 per cent in 2012.[54]

55. However, sharp geographical disparities remain. Girls in rural areas have fewer opportunities to access education and succeed academically than those in urban areas. The dropout rate is higher among girls. Domestic chores, sexual abuse in school and early pregnancy and marriage contribute to academic failure. Child labour among those under the age of 18, which is estimated to be 36.7 per cent (of whom 30.2 per cent are girls and 21 per cent are girls under 15), represents another impediment to education. The failure to enforce compulsory education for children between the ages of 6 and 16 is often compounded by a loss of class time resulting from teacher strikes.

56. Early marriage and pregnancy rob 9 per cent of girls between the ages of 7 and 14 of the opportunity to continue their studies. This rate is 13 per cent in rural areas, where the population is more attached to conservative values that lead to early marriage.[55] Despite the issuance of a circular prohibiting the expulsion of girls on the grounds of pregnancy, their education continues to be interrupted and some never return. Consequently, they are not only stigmatized, but their future prospects are also narrowed. In addition, girls are exposed to violence on their way to school, especially in rural areas. Reporting mechanisms should systematically be set up in schools for the purpose of detecting any violence or abuse.

57. The Working Group is concerned that girls do not progress to higher levels of education at the same rate as boys. In 2011, girls accounted for only 43.3 per cent of

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[51] *La Citoyenne*, revue de l'Association des juristes sénégalaises, janvier 2015.

[52] Aussi, les projets de financement de microentreprises rurales semblent avoir bénéficié davantage aux hommes (56 %). Les femmes représentent seulement 11,2 % du volume de crédit total accordé par la Caisse nationale de crédit agricole du Sénégal (CNCAS) en 2013.

[53] Rapport national sur la situation de l'éducation 2012, Ministère de l'éducation nationale.

[54] Banque de données de la Banque mondiale.

[55] *Rapport de synthèse de la deuxième enquête sénégalaise auprès des ménages* (ESAM-II), Ministère de l'économie, des finances, Direction de la prévision et de la statistique, juillet 2004, p. 73. Voir également le paragraphe 72 ci-après.

students at the secondary level.[56] Only 33 per cent of secondary school graduates who go on to higher education are women.[57] Moreover, women represent less than 5 per cent of all students in industrial, vocational and technical streams.[58]

C. Political and public life

58. Senegal has made considerable progress with regard to women's participation in political life. In 2012, for the first time in a presidential election, there were two women standing for election. The 2010 Act on Absolute Parity in Elected and Partially Elected Bodies (Parity Act) marked a historic turning point in efforts to promote women's political participation in Senegal. The country now ranks sixth in the world in terms of its number of women parliamentarians:[59] 64 of 150 deputies in Senegal are women, who account for 42.7 per cent of the National Assembly (compared to 21.3 per cent in 2007[60]). The Working Group welcomes the adoption in June 2015 of a law providing for the amendment of the rules of procedure of the National Assembly and ensuring parity within the latter's executive committee. The national rate of women's participation in local bodies has tripled from the previous to the current term, increasing from 15.9 per cent to 47.2 per cent, respectively. Senegal also has a woman First Vice-President of the National Assembly, a woman President of the Economic, Social and Environmental Council and a woman Director-General of the National Police.

59. However, the local elections held in 2014 showed that the political marginalization of women in Senegal continues to be a problem. Female candidates faced major opposition from several influential religious groups and political figures, but also from the general public, including women themselves. After the elections, it became apparent that there had not been full compliance with the Act by all bodies at the local level.[61] This resistance to compliance with the 2010 Parity Act shows that the Act has not been fully accepted and that considerable efforts are still needed to eliminate all forms of discrimination and negative stereotypes that are deeply rooted in Senegalese culture and hinder women's equal participation in decision-making bodies.

60. Accordingly, the Working Group welcomes the decisions of the Dakar Court of Appeal and the Supreme Court to declare null and void the election of the mayor and deputies of the municipalities of Keur Massar and Kaolack on grounds of non-compliance with the Parity Act, and it encourages the relevant authorities to implement these decisions as soon as possible. At the same time, it is concerned that a non-balanced list was approved during local elections in Touba and that no appeal was lodged against this decision.

61. Many stakeholders drew attention to problems in obtaining full compliance with parity in the departmental majority voting system and in elections for local executive committees (of municipalities and departments). Unfortunately, out of the 557 municipalities, only 13 currently had women mayors,[62] and out of 42 departmental councils,

[56] Rapport national du Sénégal, Mise en œuvre de la Déclaration et du Programme d'Action de Beijing+20, avril 2014, p. 13.

[57] Information fournie par le Ministère de l'éducation nationale.

[58] Rapport national du Sénégal, Mise en œuvre de la Déclaration et du Programme d'Action de Beijing+20, p. 15.

[59] www.ipu.org/wmn-e/classif.htm.

[60] La Parité, Mécanisme d'inclusion et de participation égale des femmes et des hommes aux instances de prise de décision, HCDH, ONU Femmes, AJS, OSIWA, 2014.

[61] Voir par. 60 ci-dessous.

[62] En 2009 : 11,66 % de femmes élues locales, 10 maires sur 150 (soit 6,66 %) aucune femme présidente de Conseil régional sur 14, aucune femme présidente de communauté rurale sur 349.

only 2 were presided by women. Even at the executive level, this reluctance to place women in decision-making positions is evident: out of 34 ministers and deputy ministers, only 7 are women, and their areas of responsibility are those traditionally assigned to women, including social affairs, the family and women's affairs. If the secretaries of State are included, women account for less than 18 per cent of the members of the incumbent Government.

62. Women's representation in the judicial system also remains insufficient. In 2010, women accounted for only 17.29 per cent of judicial personnel.[63] There are no women among the five members of the Constitutional Council. However, the Working Group welcomes the fact that, of the four chambers comprising the Supreme Court, two are headed by women.

IV. Right to health and access to health care

A. General context

63. The Working Group observed that women's health in Senegal was primarily affected by: (a) poor sanitary conditions; (b) limited access to water, especially drinking water, giving rise to infectious and parasitic diseases; (c) lack of information and understanding of their rights and of their sexual and reproductive health, leading to first pregnancies at an early age and a high birth rate (an average of nearly five children per woman);[64] (d) a much higher prevalence of HIV/AIDS among women, even though the epidemic has been contained in recent years[65] (women account for 61 per cent of all infected adults, the national average is 0.5 per cent but rises to 18.5 per cent for women in prostitution); and (e) harmful customs and practices, such as female genital mutilation and early marriage.

64. The Working Group welcomes the introduction in 2013 of universal health coverage, which should lead to an improvement in the provision of health care to women, children and vulnerable persons. In addition, Senegal has made childbirth and caesarean section services widely available at no cost. However, the fact that the caesarean surgery itself is free of charge does little to ease the financial burden borne by families, who have to pay for prenatal care (medicines, medical consultations) and the "medical kit" used before and after a caesarean section. The Working Group also welcomes the efforts undertaken to prevent and control malaria through the National Health Development Plan (distribution of free insecticide-treated mosquito nets and free treatment for children and pregnant women).

65. The Working Group nevertheless is concerned at the meagre level of resources allocated to health (4.2 per cent of gross domestic product and decreasing, according to World Bank figures);[66] the frequent difficulties encountered in accessing health facilities; the lack of qualified staff and adequate materials and equipment in health facilities, especially in rural areas; the persistently high cost of services; the limited availability of good quality emergency obstetric and neonatal care; and the fact that the sexual health of adolescents is scarcely taken into account in projects and programmes.

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[63] Rapport national du Sénégal, Mise en œuvre de la Déclaration et du Programme d'Action de Beijing+20, p. 38.

[64] www.ansd.sn/ressources/publications/6-%20fecondite%20sterilite.pdf.

[65] De 2,25 % en 2005 à 1,6 % en 2011.

[66] http://donnees.banquemondiale.org/indicateur/SH.XPD.TOTL.ZS.

Early marriage and pregnancy

66. Early marriage has a damaging effect on the health of girls (in addition to its negative impact on their schooling and future prospects).[67] The early marriage rate remains very high in Senegal: 40 per cent of women get married before the age of 18, whereas the age of first marriage for men is much higher. The proportion of women between the ages of 15 and 19 who are married is 23.8 per cent.[68] This rate is higher in rural areas and among the poorest members of the population. In polygamous marriages, there is a growing tendency for the age of the second, third and fourth wives to be younger than was previously the case. These early marriages usually result in early pregnancies, which girls might wish or need to terminate, especially for health reasons, but which they are currently prohibited from terminating. Sixteen per cent of girls between the ages of 15 and 19 already have one child. The rate of childbirth among adolescent girls in rural areas (25 per cent) tends to be much higher than those in urban areas (12 per cent), and this rate increases to 43 per cent in some regions of the country.[69]

67. As underscored by the World Health Organization (WHO), teenage pregnancy is extremely dangerous for girls' health. The risk of maternal mortality is four times higher among girls under the age of 16, and 65 per cent of women suffering from obstetric fistula developed it during an early pregnancy and are subject to the grave consequences it has on their life. Teenage pregnancy is also dangerous to the baby, increasing its mortality rate by 50 per cent, and, in addition, has a negative impact on the socioeconomic development of communities.[70] As many experts have pointed out, these early pregnancies may also be the result of an act of rape.[71]

B. Sexual and reproductive health and rights

68. Maternal mortality, which is a particularly telling indicator of the status of women, women's access to health care and the way in which the health-care system responds to their needs, remains very high. Every day in Senegal, five women die giving birth.[72] The maternal mortality rate is 392/100,000.[73] This is despite an increase in the rate of prenatal consultation (from 39.8 per cent in 2005 to 50 per cent in 2011) and an increase in the rate of deliveries attended by qualified health workers (from 51.9 per cent to 65.1 per cent).[74]

69. According to the information received, women often face barriers in terms of access to care during pregnancy, owing primarily to financial constraints or to problems in accessing health facilities. Despite efforts to establish health posts in rural areas, these are still too remote from certain communities and are frequently ill-equipped or ill-adapted to the needs of women (in terms of providing for traditional childbirth, for example). The Working Group welcomes the many prevention and awareness-raising programmes undertaken at the community level, such as those relating to the Badianou Gokh (community patroness/travelling midwife), who serves as a liaison between the community and the health centre or health post.

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[67] Voir par. 56.

[68] Enquête démographique et de santé (EDS) 2010-2011.

[69] Ibid.

[70] www.who.int/maternal_child_adolescent/topics/maternal/adolescent_pregnancy/en/.

[71] Voir par. 75 et 76.

[72] Campagne contre les mariages d'enfants et les pratiques néfastes, Ministère de la femme, de la famille et de l'enfance.

[73] EDS continue 2012-2013.

[74] Rapport national du Sénégal, Mise en œuvre de la Déclaration et du Programme d'Action de Beijing+20.

70. In recent years, the Senegalese authorities have increased contraceptive prevalence by means of a family planning programme. In 2014, 20 per cent of married women used some method of contraception.[75] The Act of 2005 on Reproductive Health has not yet led to a radical change in attitudes. All the health workers met with and many women admitted that they could not use contraceptives because their husband would not allow it.

71. The Working Group observed that the Senegalese abortion legislation was one of the most restrictive in Africa.[76] Article 14 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), which was ratified by Senegal in 2004, requires States parties to authorize therapeutic abortion to women and girls who become pregnant as a result of incest, rape or any other form of sexual assault, or where the mental or physical health of the pregnant woman or girl is endangered or where there is a risk to the life of the pregnant woman or girl or the baby. More than 10 years after the ratification of the Maputo Protocol, Senegal still has not harmonized its Criminal Code with the provisions of that instrument. International human rights law recognizes that the enjoyment of the highest attainable standard of health, including reproductive health, is a fundamental right.[77]

72. Some of the actors met with underscored that this extremely restrictive legislation disproportionately penalizes women from disadvantaged socioeconomic backgrounds (a large majority of women) who cannot afford to pay for a therapeutic abortion in a private clinic, which only a very small minority of persons can do. Approximately 8 to 13 per cent of maternal deaths in Senegal are caused by clandestine abortions.[78] The Working Group strongly supports the Criminal Code reform that is under way to extend therapeutic abortion to include cases of rape and incest. However, even this reform proposal is limited in that it does not take into account risks to the mother's mental health or cases of serious malformation of the fetus or a non-viable fetus. In its concluding observations of July 2015, the Committee on the Elimination of Discrimination against Women recommended that Senegal should legalize abortion and ensure that it is legally authorized in cases where the life or health of the pregnant woman is at stake, and in cases of rape, incest or severe fetal malformation.[79] The Working Group supports this recommendation and considers that, in view of the high prevalence of sexual violence and the severe threats it poses to girls' health, abortion should also be systematically permitted for girls under the age of 16.

V. Violence against women

73. All stakeholders met with during the visit expressed alarm at the high prevalence of all forms of violence against women, which was committed in a context of structural

[75] EDS continue, 2014.

[76] Voir par. 23.

[77] La Convention sur l'élimination de toutes les formes de discrimination à l'égard des femmes consacre le droit pour la femme d'avoir une maîtrise de sa fécondité. Le Comité pour l'élimination de la discrimination à l'égard des femmes a fortement désapprouvé les lois qui restreignent l'interruption volontaire de grossesse (IVG), en particulier celles qui l'interdisent et l'incriminent dans toutes les circonstances. Il a confirmé que ces législations n'empêchent pas les femmes de recourir à des IVG illégales et risquées et a qualifié les lois restrictives sur l'IVG de violation des droits à la vie, à la santé et à l'information. Différents comités et procédures spéciales ont exprimé des préoccupations similaires.

[78] Fadel Diadhiou, E.O. Faye et al., *Mortalité et morbidité liées aux avortements provoqués clandestins dans quatre sites de référence dakarois au Sénégal*, Clinique gynécologique et obstétricale du CHU le Dantec, Dakar, 1995.

[79] CEDAW/C/SEN/CO/3-7, par. 31 *c*.

inequality based on conservative patriarchal attitudes and values. Some condemned violence against women and girls as one of the foremost social problems of Senegal, taking the form of domestic violence, abuse, exploitation, sexual violence, female genital mutilation and forced marriage. Moreover, they all deplored the severe shortage of statistics and disaggregated data on this issue and stressed the alarming number of cases of rape, incest, sexual harassment and domestic violence (verbal, psychological, physical and sexual), unanimously recognizing that violence against women is a serious and widespread problem that requires urgent action at all levels.

74. The Committee on Eliminating Violence against Women and Children reported that the vast majority of these acts of violence take place in the family context. All actors involved in efforts to stop such violence pointed to the severe lack of shelters for women and girl victims of domestic violence. At the same time, the real magnitude of these phenomena is difficult to gauge, owing to underreporting and recourse to amicable settlements. The maintenance of family unity often prevails at the expense of respect for women's rights.

A. Sexual abuse of girls

75. The Working Group expresses its profound concern at the level of sexual violence to which girls are subjected, particularly at school, which is often followed by early pregnancy. The Working Group considers it intolerable that at school, which is supposed to be an educational and protective environment, girls are being sexually abused, and often by their teachers.

76. According to statistics collected by the observatories for child abuse and child sexual abuse, more than half of all girls who are raped and become pregnant thereafter are between the ages of 11 and 15. These girls often drop out of school and are subject to complete social exclusion and are confined to the home environment. Pregnancy ends the girl's life as a child. According to the information received, aggressors are often a relative or someone close to the family.

77. The Working Group finds it regrettable that only a small number of convictions are handed down for sexual abuse and that proceedings involving minors are not held in camera, which reinforces the stigmatization of girl victims and increases their chances of revictimization and exclusion. Many respondents expressed doubts about the transparency of proceedings and criticized the fact that victims were not systematically provided access to qualified legal counsel.

B. Female genital mutilation

78. Putting an end to female genital mutilation has, in recent years, been a priority objective of the Government's policy on protecting women's human rights and combating gender-based violence. Despite efforts undertaken at the legal, institutional and political levels, and a slight decrease in the prevalence of the practice, the Working Group was alarmed to observe that 25 per cent of women aged 15 to 49 reported having been a victim of excision — a rate that rose to as much as 92 per cent in some localities.[80] Thirteen per cent of girls under the age of 15 have been excised.[81] Eleven per cent of girls who are currently between the ages of 0 and 4 years, and nearly twice as many of those between the

[80] Demographic and Health Survey of Gabon 2010-2011.
[81] EDS continue 2014.

ages of 5 and 9 (21 per cent) have been excised. Twenty-five per cent of girls currently between the ages of 10 and 14 have been excised.[82]

79. Despite the adoption of a law prohibiting excision in 1999 and many prevention campaigns, all the actors consulted said that the practice persists, especially in the most remote areas. It seems that some opinion leaders and marabouts have been pushing for the continuation of excision. Drastic measures must be taken and no effort spared to eradicate this abhorrent form of violence that has serious and irreversible psychological and physical consequences for girls and women and that can even result in death following the procedure itself or during childbirth. It is vital to encourage women to report this practice and to punish severely those responsible for it, even if the mutilation was carried out abroad. Since the Act was adopted, which was more than 15 years ago, only nine complaints have been registered.[83] The penalty has a deterrent effect and represents one of the best tools for prevention. No belief or custom may be invoked or misinterpreted as justification for violating the rights of women and girls or for torturing or oppressing them.

80. Many activities involving local communities and religious and opinion leaders have been undertaken to combat this form of violence, in particular by civil society organizations and technical and financial partners working in conjunction with the Government. Nevertheless, the Working Group notes with concern that there is no overarching policy and specific budget item for countering gender-based violence. The legal measures and the programmes adopted by the Government to combat this scourge have thus far produced a fragmented response. Moreover, the lack of reliable statistical data on acts of violence and the factors associated with them hinders the development, implementation and evaluation of effective strategies to combat violence against women.

81. It is also vital to strengthen the system of prevention and elimination of violence against women by providing shelters where victims of violence can receive support and accommodation. The predominance of amicable settlements between families, the difficulties experienced by women and girls, especially in rural areas, with obtaining access to judicial and legal services, as well as insufficient knowledge on the part of law enforcement officials about laws and regulations prohibiting these forms of violence undermine efforts to combat them.[84]

C. Women victims of multiple forms of discrimination

82. The situation of women who are deprived of their liberty is also of concern to the Working Group. Although women account for only 4 per cent of the prison population, their number continues to grow. The main causes of incarceration of women are drug trafficking (31 per cent) and infanticide (16 per cent).[85] Three per cent of women were in prison as a result of an abortion and 1 per cent for involvement in prostitution.[86] Prison conditions are characterized by dilapidated and cramped facilities, lack of separate cells for women in some prisons and the absence of conjugal visits. Women are doubly stigmatized

[82] Ibid.

[83] Information fournie par le Ministère de la femme, de la famille et de l'enfance.

[84] Voir par. 27.

[85] Le crime d'infanticide est souvent la conséquence de situations de discrimination ou de violence préexistantes, notamment de grossesses issues de violences sexuelles.

[86] La prostitution, qui est légale au Sénégal, devient un délit passible d'emprisonnement dès lors qu'une travailleuse du sexe/femme en situation de prostitution n'est pas détentrice d'un carnet de santé ou n'est pas enregistrée au registre administratif. The implementation of this measure leads to a situation in which women exclusively are incriminated.

and even run the risk of losing custody of their child.[87] The Working Group was informed that the conditions of detention of pregnant women and women with small children are not in conformity with the relevant international standards.[88] The Working Group encourages alternative sentences for women,[89] in particular pregnant women and/or mothers of children under the age of 2. Lengthy pretrial detention must also be avoided.

83. The Working Group was also informed that lesbian women suffer from considerable violence, stigmatization and exclusion, even within civil society organizations involved in the promotion of gender equality, and do not at all feel supported in their struggle.

84. Women with disabilities are also in an extremely vulnerable situation and are the victims of multiple forms of discrimination owing to their social exclusion and to their limited access to education, employment, health services, public places (such as markets) and public facilities and buildings.

VI. Best practices

85. The Working Group welcomes the extensive actions undertaken to promote and protect women's rights by legal aid clinics (*boutiques du droit*), whose work is geared towards improving access to legal services for survivors of violence. Their purpose is to promote and popularize human rights, contribute to their protection, in particular for women and children, and provide support, assistance, advice and training to the general public. The legal aid clinics provide free legal support and advice. They sometimes cover fees for medical and psychosocial treatment, as well as lawyers' fees, where necessary. In addition, a free hotline was set up for women who cannot come in person to the clinics. This assistance is provided through the work of volunteer lawyers and paralegals with training in violence prevention and victim assistance. The Working Group encourages the Government to ensure the sustainability of these organizations and to avoid a situation in which their operations become dependent on donations from technical and financial partners.

VII. Conclusions and recommendations

A. Conclusions

86. **Despite the significant progress Senegal has made in terms of its legislation and the many policies it has developed for the promotion of women's rights and gender equality, Senegal must redouble its efforts to ensure that effect is given to women's rights. The rule of law must be strengthened through the promotion of a culture of respect for the rights of women and girls.**

87. **In order to accomplish this, Senegal must bring its legislation into line with international legal instruments on women's human rights and fiercely combat cultural resistance to women's full enjoyment of their rights. The Senegalese Constitution provides for the establishment of a secular Republic that cannot allow harmful**

[87] Rapport du CESE 2014.

[88] Règles des Nations Unies concernant le traitement des détenues et l'imposition de mesures non privatives de liberté aux délinquantes (Règles de Bangkok), résolution 65/229 de l'Assemblée générale, en date du 21 décembre 2010.

[89] Causes, conditions et conséquences de l'incarcération des femmes, rapport de la Rapporteuse spéciale sur la violence contre les femmes, ses causes et ses conséquences (A/68/340), par. 85.

cultural considerations to take precedence over the rules of international law regarding women's human rights or to hold sway over the effective implementation of laws and the formulation of policy.

88. As indicated by the special procedures and human rights treaty bodies, freedom of religion may not be used to justify discrimination against women. It is intolerable that, under the pretext of tradition, custom or even poverty, girls and women are denied their fundamental human rights, and are attacked, abused and subjected to indecency.

89. Women's empowerment is central to their advancement. In order to break the chains of silence and inequality, Senegalese women must have access to quality education and complete it. They must be properly trained and informed, have access to income-generating activities that ensure sustainable economic development and be able to rely on a system of justice that is accessible to all without distinction. The suppression of corruption and impunity is a key factor in obtaining access to effective justice.

90. The coordination framework for all stakeholders involved in the promotion of women's rights must be strengthened and must be conducive to the effective implementation of all policies and programmes.

B. Recommendations

91. With regard to the legal framework, the Working Group recommends that the Government:

(a) Ratify International Labour Organization (ILO) Domestic Workers Convention, 2011 (No. 189) and the Maternity Protection Convention, 2000 (No. 183);

(b) Amend the Family Code in order to eliminate, in law and in practice, all forms of discrimination in the family, including forms of marriage that limit or deny the rights, well-being and dignity of women and girls [early marriage (art. 111) and/or forced marriage, and polygamous marriage (art. 116)], the choice of the conjugal home, which is the sole prerogative of the husband (art. 153), the exercise of parental authority by the father (art. 277), the persistence of the husband's "marital authority" over his wife (art. 152) and inequality in respect of inheritance (art. 637);

(c) Raise the legal age of marriage for women to 18 and include a new provision in the Criminal Code that penalizes early marriage;

(d) Adopt land reforms that introduce quotas in order to ensure equal access to land;

(e) Legalize abortion, as provided for in the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) and extend it to include girls under the age of 16, in view of the severe risks pregnancy poses to their health;

(f) Adopt comprehensive legislation that prohibits any form of gender-based violence;

(g) Completely abolish the penalization of women who are involved in prostitution;

(h) Reform the Code of Criminal Procedure in order to allow associations to sue for damages in civil proceedings;

(i) **Ensure the effective implementation of the existing legal framework for the protection of women's rights and gender equality.**

92. **At the institutional level, the Working Group recommends that the Government:**

(a) **Strengthen the leadership of the Ministry of Women, the Family and Children;**

(b) **Strengthen the National Observatory on Gender Parity, and assign it an adequate budget;**

(c) **Strengthen the Senegalese Human Rights Committee with a view to bringing it into line with the Paris Principles, and set up within it a subcommission on the rights of women;**

(d) **Assign specific budgets to gender units attached to ministries that have staff working to incorporate gender into policy implementation and ensure that gender-sensitive budgets are developed on a systematic basis.**

93. **In the area of access to justice, the Working Group recommends that the Government:**

(a) **Provide proper training to all judicial personnel beginning with their initial training, and complement it with in-service training at regular intervals throughout their career;**

(b) **Mobilize the entire judicial system to combat impunity;**

(c) **Disseminate information on and raise awareness of the rights of women and girls among all segments of the population through the involvement of the media, men and boys, as well as community and religious leaders;**

(d) **Recruit more women officers in police stations and gendarmeries in order to handle the cases of girls and women who have been subjected to violence;**

(e) **Establish centres that offer a combination of all necessary services for victims of violence, such as medical, legal and psychosocial assistance, including at the local level;**

(f) **Establish reporting mechanisms in schools in order to detect any violence or abuse;**

(g) **Provide free medical certificates in cases of sexual violence;**

(h) **Facilitate as far as possible the public's efforts to obtain civil registry documents (birth and marriage certificates), and properly train officials of the relevant administrative offices;**

(i) **Strengthen efforts to promote community-based justice mechanisms and to ensure that these mechanisms are not used for reaching amicable settlements in cases of violence;**

(j) **Ensure that perpetrators of gender-based violence are prosecuted and convicted, including those responsible for female genital mutilation.**

94. **With regard to policy implementation, the Working Group recommends that the Government:**

(a) **Strengthen the promotion of protective social norms, especially at the community level;**

(b) **Include women's human rights and gender equality in school curricula, beginning at the level of primary education;**

(c) **Increase men's awareness of their shared responsibility for the upbringing of children and for dependent parents, as well as a more equitable sharing of domestic chores;**

(d) **Introduce temporary special measures, such as quotas, in order to address the problem of discrimination against women in employment, not only in elected positions, but also in the civil service (including at high levels of public administration, such as prefect or governor) and in private companies, in order to ensure that Senegalese women have that same opportunities as men;**

(e) **Ensure that women living in poverty, especially those in rural areas, have increasingly egalitarian access to resources and credit and are provided with capacity-building;**

(f) **Adopt urgent measures to ensure decent work for all female workers, particularly domestic workers and rural women;**

(g) **Develop studies at the national and local scales with the aim of collecting detailed and disaggregated data on all forms of gender-based violence;**

(h) **Increase the presence of women in the judicial system, including in the highest judicial bodies;**

(i) **Take all necessary measures to ensure girls' access to all types and levels of education and training, as well as to ensure their retention and performance, and strenuously combat the causes of dropout from school on the part of girls;**

(j) **Strengthen all actions and budgets related to family planning and provide entirely cost-free access to modern contraceptive methods, in particular with a view to preventing early pregnancy, and develop special protocols for adolescents;**

(k) **Pursue efforts to combat the feminization of HIV/AIDS, in particular for groups of women with a high prevalence rate, and ensure that women in prostitution systematically have access to a system of free prevention and treatment;**

(l) **To the extent possible, formulate alternative penalties for women, especially pregnant women and/or mothers of children under 2 years of age, and avoid lengthy pretrial detention, in accordance with the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (Bangkok Rules);**

(m) **Systematically incorporate training modules on gender equality in journalism training programmes and implement monitoring mechanisms intended to ensure the equal participation of women in the media and the promotion and protection of their rights by all means of communication.**

95. **The Special Rapporteur recommends that the country's technical and financial partners:**

(a) **Ensure the effective harmonization of the framework of cooperation with a view to avoiding the fragmentation of actions and project approaches that do not ensure programme sustainability or sustainable development for women;**

(b) **Strengthen and support the women's social movement, which is confronted with highly organized conservative forces;**

(c) **Ensure the systematic monitoring of aid programmes to assess their genuine impact and the presentation of transparent accounts.**

United Nations

A/HRC/32/44/Add.2

General Assembly

Distr.: General
4 August 2016

Original: English

Human Rights Council
Thirty-second session
Agenda item 3
Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Report of the Working Group on the issue of discrimination against women in law and in practice on its mission to the United States of America*

Note by the Secretariat

The Secretariat has the honour to transmit to the Human Rights Council the report of the Working Group on the issue of discrimination against women in law and in practice on its visit to the United States of America, conducted from 30 November to 11 December 2015. The report describes the situation regarding gender equality and the human rights of women in the country and analyses achievements and challenges. It examines the legal, institutional and policy framework for promoting equality and the participation and empowerment of women in economic, social, political and public life, with particular attention to women victims of multiple forms of discrimination. The Working Group presents its recommendations for further progress in eliminating discrimination and promoting equality.

* The present report was submitted after the deadline in order to reflect the most recent developments.

GE.16-13535(E)

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Report of the Working Group on the issue of discrimination against women in law and in practice on its mission to the United States of America**

Contents

		Page
I.	Introduction	3
	A. The visit	3
	B. Context	3
II.	Legal, institutional and policy framework for women's equality and human rights	4
	A Legal framework	4
	B. Access to justice	8
	C. Institutional framework and policies at the federal level	9
III.	Participation of women in political and public life and in economic and social life, and access to health	10
	A. Participation in political and public life	10
	B. Participation in economic and social life	11
	C. Access to health care	15
IV.	Gender-based violence and women victims of multiple forms of discrimination	18
V.	Conclusions and recommendations	20
	A. Conclusions	20
	B. Recommendations	21

** Circulated in the language of submission only.

I. Introduction

A. The visit

1. The Working Group on the issue of discrimination against women in law and in practice visited the United States of America from 30 November to 11 December 2015 at the invitation of the Government. The Working Group met with various concerned stakeholders in Washington, D.C., Austin and McAllen (Texas), Montgomery and Lowndes County (Alabama) and Salem and Portland (Oregon). The experts wish to thank the federal and state authorities as well as civil society organizations for their assistance in the organization of this visit.

2. In Washington, D.C., the Group met with representatives of the Departments of State, Labor, Health and Human Services, Education, Justice, Homeland Security and Housing and Urban Development; the White House Council on Women and Girls; the White House Advisor on Violence against Women; the Equal Employment Opportunity Commission; and the Office of Personnel Management. The Working Group also met with members of Congress, a judge of the Superior Court of the District of Columbia and a member of the National Association of Women Judges. In Austin, the Working Group met with representatives of the Commission for Women, the Office of the Speaker of the Texas House of Representatives and state trial judges. In McAllen, it met with the office of the Assistant City Manager. In Montgomery, it met with the Lieutenant Governor, a judge of the Middle District Court and a legislator. In Salem, it met with the Attorney General and the Office of Child Care. In Portland, it met with a District Court judge and the Oregon Commission for Women, including the Commissioner.

3. During its visit, the Working Group met with numerous non-governmental organizations, visited the Coffee Creek Penitentiary (Oregon), health centres, abortion clinics, childcare centres and relief nurseries. The Working Group would like to express its sincere gratitude for the exceptional level of cooperation and support extended by civil society during the visit.

B. Context

4. The visit of the Working Group took place at a moment when the political rhetoric of some of the candidates for the presidency in the upcoming elections included unprecedented hostile stereotyping of women; when there were increasingly restrictive legislative measures at the state level and violent attacks to prevent women from exercising their rights to reproductive health;[1] and when there was a significant and disparate worsening of the economic situation of women, in particular women of colour.

5. The Working Group acknowledges the commitment of the United States to liberty, so well represented by the Statue of Liberty, which symbolizes both womanhood and freedom. Nevertheless, in the global context, women in the United States do not take their due place as citizens of the world's leading economy, which has one of the highest per capita incomes. In the United States, women fall behind as regards their public and political representation, their economic and social rights and their health and safety protections.

[1] On 27 November 2015, a gunman attacked a Planned Parenthood clinic in Colorado. Three people were killed and several others injured.

6. Coming as it did at a time when the economy already had a high level of socioeconomic inequality, the global economic crisis further increased economic insecurity for the middle and lower deciles of the population and had a significantly adverse impact on women, in particular women of colour.[2] Government recovery policies to boost the economy resulted in decreased expenditures on critical social protection programmes, many of which were essential for women.

7. The experts are fully aware of the diversity of the United States and of its political and legal framework, which combines federal and state legislation. Accordingly, the Working Group, rather than reviewing multitudinous provisions, and in view of the word limit on documents, comprehensively seeks to extract the key features of national policy, selected examples of state policy, the most recent trends in women's political, civil, social and economic situation and the achievements and obstacles encountered in promoting gender equality.

II. Legal, institutional and policy framework for women's equality and human rights

A. Legal framework

1. Ratification of conventions at the international and regional levels

8. The United States ratified the International Covenant on Civil and Political Rights (1992), the International Convention on the Elimination of All Forms of Racial Discrimination (1994), the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1994) and the Optional Protocols to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography and on the involvement of children in armed conflict (2002).

9. The Working Group deeply regrets that the United States has not ratified the Convention on the Elimination of All Forms of Discrimination against Women and its Optional Protocol. In 2010 and 2015, in the framework of the universal periodic review, the Government committed to ratifying the Convention but has not yet done so. The Working Group notes that resistance to ratification of the Convention reflects, inter alia, the opposition of a powerful sector of society to the Convention's formulation of women's international human right to equality. The United States is one of only seven countries in the world which have not ratified the Convention. Even in the absence of ratification, many of the Convention standards are entrenched, inter alia, in the Universal Declaration of Human Rights and in the International Covenant on Civil and Political Rights and are hence binding on the United States. Nevertheless, the Working Group is of the unreserved opinion that ratification of the Convention is crucial, on both the domestic and the global level, in order to confirm the commitment of the United States to substantive equality for women in all spheres of life. At the domestic level, ratification is essential in order to provide all women in the country with "missing" rights and protections guaranteed under the Convention, such as universal paid maternity leave, accessible reproductive health care and equal opportunity in standing for political election. The Working Group welcomes in this regard the initiatives undertaken by

[2] See also the statement to the media by the Working Group of Experts on People of African Descent on its visit to the United States, available from www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=17000&LangID=E.

"Cities for CEDAW", which has started a process of incorporating Convention principles at the local level.

10. The Working Group also deeply regrets that the United States has not ratified other major international and regional human rights instruments that have a direct impact on the rights of women, such as the International Covenant on Economic, Social and Cultural Rights; the Convention on the Rights of the Child; the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families; the Convention on the Rights of Persons with Disabilities; and the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women "Convention of Belém do Pará". It further regrets that it is not party to the Equal Remuneration Convention, 1951 (No. 100), the Workers with Family Responsibilities Convention, 1981 (No. 156), the Indigenous and Tribal Peoples Convention, 1989 (No. 169), the Maternity Protection Convention, 2000 (No. 183) and the Domestic Workers Convention, 2011 (No. 189) of the International Labour Organization (ILO).

2. Main achievements in prohibiting discrimination and violence against women

11. The experts recognize the very significant protection for women's rights under federal legislation and under the Constitution and greatly appreciate landmark decisions, in particular of the Supreme Court,[3] which have created benchmarks in prohibiting sex discrimination. They note, in particular, the following.

Employment rights

12. The Equal Pay Act of 1963 requires that men and women in the same workplace be given equal pay for equal work.

13. Title VII of the Civil Rights Act of 1964 prohibits employment discrimination, including sexual harassment, based on race, colour, religion, sex or national origin by employers with 15 or more employees.[4]

14. The Pregnancy Discrimination Act of 1978, amending Title VII, prohibits sex discrimination on the basis of pregnancy and clarifies that employment discrimination on the basis of pregnancy, childbirth or related medical conditions constitutes sex discrimination under Title VII.[5]

15. The Family and Medical Leave Act (1993) provides employees with the right to take unpaid, job-protected leave of 12 workweeks in a 12-month period, including for the birth of a child and to care for the newborn, within one year of the birth.

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[3] See www.aclu.org/files/interactive/womensrights_scotus_0303a.html#00.

[4] While the Equal Pay Act is limited to jobs within the same workplace, Title VII does not have this limitation. In 1981, four female prison guards sued Washington County in Oregon under Title VII for paying them less than male prison guards: in *County of Washington v. Gunther*, the Court clarified that claims of wage discrimination brought under Title VII were not limited to equal pay for the exact same work, as they are under the Equal Pay Act.

[5] Only Indiana and North Carolina do not offer any protections against discrimination based on pregnancy discrimination. In Texas and 13 other states, employers, by law, must provide reasonable accommodations for pregnant workers. Oregon and 18 other states have passed laws providing workplace breastfeeding rights (such as break times and a private space for pumping breast milk). South Dakota, Nevada and Alabama provide that employers must allow pregnant employees to take sickness or disability leave owed to them for pregnancy-related conditions.

16. The Lilly Ledbetter Fair Pay Restoration Act (2009)[6] and Executive Order 13665 (2014) promote pay transparency and provide more effective procedures for challenging unequal pay.

Education

17. Title IX of the Education Amendments of 1972 prohibits sex discrimination in federally funded educational programmes.

Same-sex marriage

18. In its 2015 landmark decision in *Obergefell v. Hodges*, the Supreme Court recognized same-sex marriage as a constitutional right under the Fourteenth Amendment to the Constitution.

Right to health

19. The adoption of the Affordable Care Act in 2010 expanded access to health care for many uninsured citizens, with the biggest gains for the poor, minorities and low-wage workers. The legislation marked significant progress in women's enjoyment of the right to health. The Act also established crucial protections against discriminatory practices by health insurance plans in terms of charges and coverage relating to women's reproductive health needs as well as provisions for coverage of provider screening and counselling for domestic violence.

Violence against women

20. The Violence against Women Act of 1994 as last reauthorized in 2013, is a key resource to prevent gender-based violence, specifically domestic violence, sexual assault, date violence and stalking (see A/HRC/17/26/Add.5 and Corr.1, paras. 67-71). There are also statutory protections at state and local levels. The last reauthorization of the Act created earmarked funding to support sexual assault response teams and to train law enforcement officers and prosecutors in how to deal with sexual assault, and explicitly barred discrimination based on gender identity or sexual orientation

21. The Working Group also notes the adoption in 2012 of the National Standards to Prevent, Detect, and Respond to Prison Rape, pursuant to the Prison Rape Elimination Act (2003).

22. The experts welcome the significant legislative and judicial measures taken in the past decades aimed at eliminating discrimination and violence against women. Nonetheless, the Working Group notes that significant gaps remain in many of these legal frameworks and makes recommendations for further measures to guarantee gender equality in the workplace, in family status, in the right to health and as regards violence against women.

3. Challenges

Absence of an equality provision in the Constitution

23. The Working Group regrets that political resistance has consistently blocked efforts to pass an equal rights amendment, which would entrench women's right to equality in the Constitution. Constitutional guarantee is considered by leading human rights experts as crucial to secure women's right to equality and is included in almost all

[6] See https://nwlc.org/resource/lilly-ledbetter-fair-pay-act-0.

constitutions globally. According to a poll in 2012, 91 per cent of people in the United States think that the Constitution should include equal rights for men and women.[7]

24. An equal rights amendment is also essential to demonstrate genuine political will to attain substantive equality between women and men, to pre-empt legislative reversal of gains made in the protection of women's right to equality and to further strengthen the review power of the Supreme Court to strike down discrimination against women.

Marital status

25. Family law is the prerogative of the states; there are therefore numerous laws relating to marriage across the country.[8] Most states set the age of marriage at 18 without parental consent and 16 with parental consent and under certain conditions. Mississippi is the only state where women can marry without parental consent at the age of 15, and men at 17.[9]

26. Although polygamy has been illegal in all states since 1862 (Morrill Anti-Bigamy Act), some cases of polygamy have been reported, especially in Utah and Colorado. However, in December 2013, a District Court in Utah ruled, in the case *Brown v. Buhman*, that Utah's anti-polygamy law was unconstitutional on the basis of the First Amendment to the Constitution which guarantees, among other rights, religious freedom.

Guns and gender-based violence

27. A series of federal and state laws have aimed at keeping guns out of the hands of the most dangerous domestic violence offenders. The strongest state laws prohibit domestic abusers and stalkers from buying or possessing guns, require background checks for all gun sales and create processes to ensure that abusers and stalkers surrender the guns already in their possession. However, federal prohibitions apply to abusers who are currently or formerly married to their victims and those who live with or formerly lived with their victims, but do not prohibit dating partners or misdemeanant stalkers from buying or possessing guns. The experts regret that existing regulations have done little to curb the problem of guns and their role in violence against women, in particular intimate partner homicides, but welcome the actions announced by the executive in January 2016 to reduce gun violence by increasing background checks for purchasers.

Rights to reproductive and sexual health

28. The experts regret that throughout the years, women in the United States have seen their rights to sexual and reproductive health significantly eroded. Since the 1973 decision by the Supreme Court in *Roe v. Wade* that a woman has a constitutional right to choose to terminate a pregnancy in the first trimester prior to viability,[10] other Supreme Court decisions have opened the door to, inter alia, greater state regulation of abortion, barring abortion counselling and referral by family planning programmes funded under Title X of the federal Public Health Service Act; establishing the "undue burden test" providing that state regulations can survive constitutional review so long as they do not

[7] In 1972, the Equal Rights Amendment was passed by Congress with a seven-year deadline for ratification by the states (to enter into force, an amendment to the Constitution requires ratification by three quarters of the states (i.e., 38 out of 50). That number was never reached. See Jessica Neuwirth, *Equal Means Equal: Why the Time for an Equal Rights Amendment is Now* (New Press, 2015).

[8] See www.law.cornell.edu/wex/table_marriage.

[9] Mississippi Code (2013), Title 93, para. 93 1-5. Available from http://law.justia.com/codes/mississippi/2013/title-93/chapter-1/section-93-1-5/.

[10] See www.aclu.org/timeline-important-reproductive-freedom-cases-decided-supreme-court.

place a "substantial obstacle in the path of a woman seeking an abortion of a nonviable foetus"; and deciding that lawmakers can overrule a doctor's medical judgment and that the "State's interest in promoting respect for human life at all stages in the pregnancy" can outweigh a woman's interest in protecting her health.[11] Women's rights to sexual and reproductive health are constantly being challenged.

29. At the time of writing, the Supreme Court was reviewing a case (*Whole Woman's Health v. Hellerstedt*)[12] which had major implications for the future of access to essential reproductive health care in the United States. The expert group deeply hopes that this decision will reinstate the fundamental right of women to access reproductive and sexual health services in accordance with their constitutional rights.[13] The Working Group is also concerned that the Supreme Court's recognition, in the *Hobby Lobby* case,[14] of an exemption from the obligation of an employer to provide insurance that included contraception on the grounds of freedom of religion will deprive some women of the possibility of accessing contraceptives. A similar case, *Zubik v. Burwell*, concerning contraception and religious refusals, was also being heard by the Supreme Court.[15]

30. Furthermore, the Working Group deplores the adoption in 1973 of the Helms Amendment to the Foreign Assistance Act,[16] which was intended to prohibit foreign aid extended by the United States from being used to pay for the use of abortion "as a method of family planning", but is being used to justify a complete ban on using those funds for abortions, even when a pregnancy is a result of rape or incest or when a pregnancy is a threat to the life of a woman or girl. The Working Group also regrets the adoption in 1976 of the Hyde Amendment prohibiting the use of certain federal funds for abortions except in cases of rape, incest or preserving the life of the mother.

Social and economic rights

31. The Working Group regrets the important gaps in the legal framework which prevent women in the United States from fully enjoying their economic and social rights, including their equal right to work.

B. Access to justice

32. The courts play a central role in determining women's ability to enjoy and exercise the rights accorded to them by law. In the United States, there has been an increase in awareness of the need for gender diversity and gender-sensitive adjudication in judiciaries. Since the beginning of his mandate, the President has appointed more than 130 women judges. The Supreme Court has three women among its nine justices, for the

[11] See e.g. *Webster v. Reproductive Health Services* (1989); *Rust v. Sullivan* (1991); *Planned Parenthood of Southeastern Pennsylvania v. Casey* (1992); *Gonzales v. Carhart* and *Gonzales v. Planned Parenthood Federation of America, Inc.* (Carhart II) (2007).

[12] See the communication in A/HRC/29/50, p. 54.

[13] Editor's note: on 27 June 2016, the Supreme Court struck down a Texas law designed to shut down most of the state's abortion clinics by imposing medically unnecessary restrictions.

[14] *Burwell v. Hobby Lobby Stores, Inc.* (2014).

[15] Editor's note: on 16 May 2016, the Supreme Court, without deciding on the merits, unanimously decided to remand the case to the lower courts.

[16] See http://plannedparenthoodaction.org/community/planned-parenthood-global/helms-amendment-hurts-women-worldwide.

first time in its history.[17] Of the 170 active judges currently sitting on the 13 federal courts of appeal, 60 are women (35 per cent).[18]

33. A severe problem for women litigants is access to justice: free legal counsel and aid are not systematically available for women living in poverty, and when legal aid is partially provided to the most destitute, it is allegedly of very poor quality. The experts hope that the White House Legal Aid Interagency Roundtable established in September 2015 will propose concrete solutions and have an adequate budget to address this gap.

34. The institution of the class action, which has allowed large numbers of women to access compensation for discrimination or injury caused by powerful corporations, is being eroded, with particular impact on women's legal resources for fighting gender discrimination, as demonstrated in the Supreme Court's rejection in 2013 of a class action suit against Wal-Mart Stores Inc. for discrimination, brought on behalf of about one million female workers. The justices held that the petitioners had failed to identify a common corporate policy that had led to gender discrimination against workers at thousands of Wal-Mart and Sam's Club stores across the country.

35. The Working Group also remains concerned at the particular difficulties faced by Native American women in accessing justice. The nature of the interaction between federal, state and tribal jurisdictions has meant that crimes committed by non-indigenous men on reservations often go unpunished. To address this situation, in July 2010, the Tribal Law and Order Act was passed with the aim of clarifying responsibilities and increasing coordination among the various law enforcement agencies.[19] The reauthorization of the Violence against Women Act in 2013 was an attempt to remedy the criminal justice response to violence against Native American women. However, the Working Group received reports that these laws are not being fully and effectively implemented, resulting in a persistent failure of the justice system to respond adequately to acts of violence against Native American women (see CERD/C/USA/CO/7-9 and A/HRC/17/26/Add.5 and Corr.1).

36. The experts recommend that the issue of substantive equality for women in court proceedings be revisited and reinvigorated and that access to justice for all, with adequate legal representation, be regarded as a civil right which, where necessary, should be publicly funded.

C. Institutional framework and policies at the federal level

1. Institutional framework

37. The Government has considerably strengthened the institutional structure to promote women's rights and gender equality, including through the White House Council on Women and Girls and the White House Advisor on Violence against Women, which have reinforced the Civil Rights Division and the Office on Violence against Women within the Department of Justice; and the Office on Women's Health,[20] the Family Violence Prevention and Services Division and the Office of Minority Health within the Department of Health and Human Services. Other departments and federal entities also play a key role such as the Department of Labor, the Equal Employment Opportunity Commission, the Office of Personnel Management and the Commission on Civil Rights.

[17] Only 4 of the 112 justices who have served on the Supreme Court have been women.

[18] See https://nwlc.org/resources/women-federal-judiciary-still-long-way-go/.

[19] United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), *Progress of the World's Women 2011-2012: In Pursuit of Justice*, p. 73.

[20] Conducting gender-mainstreamed research.

38. The Working Group observed during its visit that federal and state authorities had very limited knowledge of international human rights standards and mechanisms. It regrets that no national human rights institution has been established in accordance with the principles relating to the status of national institutions for the promotion and protection of human rights (the Paris Principles).[21] The Working Group notes that six inter-agency working groups exist, under the leadership of the White House, to coordinate the review of the recommendations of the universal periodic review and concluding observations of treaty bodies, but regrets the absence of a mechanism which would coordinate and monitor the implementation of the recommendations of special procedures mandate holders.

2. Policies

39. The Working Group acknowledges that the promotion of gender equality and the empowerment of women and girls has been at the forefront of the current administration's policies. Indeed, the Government has been working to combat discrimination, eliminate violence against women and girls, expand access to women's health care, including sexual and reproductive health and rights, support women-owned businesses and women entrepreneurs and encourage women's economic and political leadership.[22] Several of these policies are detailed in the Government's report on the implementation of the Beijing Declaration and Platform for Action.[23]

III. Participation of women in political and public life and in economic and social life, and access to health

A. Participation in political and public life

40. Despite the current administration's commitment to advancing women's rights, adequate representation for women in political life is far from being achieved and, indeed, only 4 out of 15 Cabinet members are women.

41. Women hold 19.4 per cent of the seats in the House of Representatives and 20 per cent in the Senate. Between 2004 and 2015, the number of women in the Senate increased from 14 to 20 and the number of women in the House grew from 60 to 84. This represents the highest level of legislative representation ever achieved by women in the United States. However, it still puts the country at only 96 in the global ranking.[24] Women of colour make up 7.4 per cent (32 of 435 representatives) of the House. There is only one woman of colour serving in the Senate,[25] but not a single African-American woman.

42. Only six states have female governors: New Hampshire, New Mexico, Oklahoma, Oregon, Rhode Island and South Carolina. The share of state senate seats held by women is largest in Arizona (43.3 per cent) and smallest in South Carolina (2.2 per cent). The share

[21] The Commission on Civil Rights has the authority to undertake many of the monitoring activities of a national human rights institution, including the power to convene hearings, issue reports and make recommendations to Congress and the executive branch, but it is not fully in accordance with the Paris Principles.

[22] See www.whitehouse.gov/the-press-office/2015/09/27/fact-sheet-promoting-gender-equality-and-womens-empowerment.

[23] See www.unece.org/fileadmin/DAM/Gender/Beijing_20/United_States_Beijing_20_Review.pdf.

[24] See www.ipu.org/wmn-e/classif.htm.

[25] Mazie Hirono of Hawaii.

of seats in the state house or assembly held by women is largest in Colorado (46.2 per cent) and smallest in Oklahoma (12.9 per cent).[26]

43. According to several of the interlocutors whom the Working Group met during its visit, the low level of representation of women in elected political posts is due partly to the greater difficulties women face in fundraising for campaigns. The financing of political campaigns has increasingly played a major role in recent decades and has drastically altered the landscape of elections and political participation. The experts observed that women's difficulty in fundraising is considered to result from complex causes. In particular, it is a result of exclusion from the predominantly male political networks that promote funding. Interlocutors also attribute women's low rate of election to negative stereotypes and biased presentation of women in the media, which adversely affect both women's fundraising ability and their political candidacy. The experts consider the objective difficulties women face in raising campaign funding to be a serious limitation on women's opportunities for political representation, and are deeply concerned that the removal of limits on campaign contributions by the Supreme Court in 2014 threatens to exacerbate this situation.

44. In this regard, the Working Group welcomes the initiatives undertaken by states and cities that have started programmes for public financing of campaigns. One method, which its supporters call "Clean Money, Clean Elections", gives each candidate who chooses to participate a fixed amount of money. Some interlocutors have pointed out that, in order to effectively give women an equal chance, competing private funding would have to be restricted. The Working Group encourages the efforts deployed by voluntary organizations, such as Emily's List, which promote women candidates. The Working Group recalls that, in accordance with international human rights standards, temporary special measures have been adopted in many democratic countries to ensure more adequate representation of women in politics.

45. Furthermore, while more women currently vote than men,[27] it is essential to ensure that women continue to have access to the voting booth. Today, a patchwork of state laws is making it more and more difficult to exercise the right to vote. For instance, officials in Ohio, Texas and North Carolina have manipulated rules to keep part of the population away from the polls. The Working Group welcomes the efforts deployed by the League of Women Voters which has, for instance, successfully challenged the Florida state legislature for redrawing congressional districts for a particular party's benefit.[28] The Working Group is concerned that changes in voter identification laws, such as those in Alabama, which increase bureaucratic requirements for voter identification, are particularly problematic for women who have changed their name after marriage, and reductions in the number of voting centers can make registration and voting less accessible for the poor, a majority of whom are women. A counter example and good practice is the State of Oregon, which has facilitated voter registration and voting by mail.

B. Participation in economic and social life

46. Women's participation in the workforce has played a key role in the country's economic growth in the last decades. Women constitute nearly half of the labour force in the United States, and 57 per cent of women are labour force participants. Mothers are more likely to provide significant financial support to their families than ever before,

[26] Cynthia Hess and others, *Status of Women in the States: 2015* (Institute for Women's Policy Research, 2015).

[27] Ibid.

[28] Neuwirth, *Equal Means Equal*.

with nearly two thirds of women being primary or co-breadwinners for their families.[29] Among dual-earner couples, 29 per cent of women earned as much as or more than their husbands. Women today are more likely than men to graduate from college, and are as likely to obtain advanced degrees.[30]

47. However, while women have made great achievements in education and have increased their workforce participation, the Working Group is concerned that their crucial labour force participation and educational achievements are not accompanied by equal economic returns, especially as reflected in the wage gap and the high numbers of women earning the minimum or beneath minimum wage. It notes that, in practice, discrimination against women in employment continues; women's work is valued less and provides less favourable terms and conditions of work, including salary and promotion. Furthermore, it considers that, despite the prohibition of discrimination in employment and the establishment of the Equal Employment Opportunity Commission, the legal system does not provide women with a level playing field, failing to secure the workplace accommodations necessary for women to fulfil both reproductive and productive roles.

48. The Working Group regrets the persistence of a corporate culture that perpetuates gender stereotypes. The Working Group was informed that women own over one third of the firms in the United States, most of them small and medium-size businesses, and that these businesses face greater barriers in obtaining low-cost capital from sources such as the Small Business Administration and clearly need support to achieve equal economic potential. The federal Government has a stated goal of awarding 5 per cent of federal contracts to women-owned businesses;[31] it is reported that this goal was reached for the first time only in 2015.[32]

49. The Working Group recognizes the gains for women's equal opportunity in employment made under the equal protection guarantees of the Fourteenth and Fifth Amendments and the prohibition against employment discrimination contained in Title VII of the Civil Rights Act of 1964. It also appreciates the decisions of the Supreme Court in sex discrimination cases in which the Court has rejected the use of gender stereotypes and recognized the legitimacy of affirmative action and the discriminatory effect of sexual harassment and gender hostility in the workplace. However, in another of its decisions, the Court has made it more difficult for women to prove discrimination. In equal protection cases under the Fourteenth Amendment, the Court has traditionally applied intermediate scrutiny rather than strict scrutiny. In Title VII cases, the Court has developed two principal models for proving claims of employment discrimination. The "disparate treatment" model focuses on an employer's intent to discriminate. Alternately, the "disparate impact" model, a facially neutral employment practice, may violate Title VII even if there is no evidence of an employer's intent to discriminate. Both models require the plaintiff to establish a prima facie case of discrimination, and the burden then shifts to the employer to articulate a defence. Ultimately, however, the plaintiff retains the burden of persuasion to establish that the employer's assertion of a legitimate, non-discriminatory reason for its actions was a mere pretext. The Supreme Court has also recently circumscribed the effectiveness of using class action suits in employment discrimination claims (see para. 33).

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[29] See research by Heather Boushey, Executive Director and Chief Economist at the Washington Center for Equitable Growth and Senior Fellow at the Centre for American Progress, available from https://heatherboushey.com/writing-and-testimonies/.

[30] See www.unece.org/fileadmin/DAM/Gender/Beijing_20/United_States_Beijing_20_Review.pdf.

[31] United States Women's Chamber of Commerce.

[32] https://www.sba.gov/content/sba-federal-government-breaks-contracting-record-women-owned-small-businesses.

50. The gender wage gap is 21 per cent, and during the last decade little improvement has been made in closing it despite the Equal Pay Act of 1963. Research has shown that a woman working every year between the ages of 25 and 65 will have lost $420,000 over her working life because of the earnings gap.[33] Education increases women's earnings but does not eliminate the gap, which is in fact larger for those with the highest levels of educational attainment. In her lifetime, a woman with an advanced degree in such fields as law or medicine can expect to earn $2 million less than her male peers.[34] The wage gap affects women's income throughout their lives, affecting their financial security and independence and increasing pension poverty.

51. The wage gap may be attributed both to vertical discrimination in wage scales and to horizontal discrimination as a result of a gender-segregated labour market. In order to address the latter, international human rights standards require equal pay for work of equal value. However, in the United States, neither federal nor state equal pay laws have required equal pay for work of equal value. Exceptionally, California has now set a precedent with the California Fair Pay Act of 2015, which legislates the right to equal pay for work of equal value.

52. Women's earnings also differ considerably by ethnicity: African-American, Native American and Hispanic women have the lowest earnings. Across the largest racial and ethnic groups in the United States, Asian/Pacific Islander women have the highest median annual earnings, at $46,000,[35] followed by white women ($40,000). Native American and Hispanic women have the lowest earnings, at $31,000 and $28,000, respectively. Data also indicate that women of colour are less likely to attain a bachelor's degree or higher than other women.[36]

53. The expert group is concerned that, although the Pregnancy Discrimination Act of 1978 established that pregnancy discrimination is sex discrimination under Title VII, between 1997 and 2011, the number of pregnancy discrimination complaints filed with the Equal Employment Opportunity Commission increased by 46 per cent and pregnant women have largely continued to lose their requests for remedy.[37] The experts hope that the 2014 guidelines issued by the Commission and the decision of the Supreme Court in 2015 in *Young v. United Parcel Service*[38] will improve access to justice for pregnancy-related discrimination.[39]

54. The Working Group is appalled by the lack of mandatory standards for paid maternity leave, which is required in international human rights law. The Family and Medical Leave Act, which gives employees of companies with more than 50 employees the right to take unpaid, job-protected leave of 12 workweeks in a 12-month period, cannot be regarded as in lieu of paid maternity leave and falls far short of international human rights standards, which require that maternity leave must be paid leave for a minimum of 14 weeks; best practice is the provision of paid leave for fathers too. Some form of paid parental leave is provided by legislation in three states,[40] but only for six

[33] Neuwirth, *Equal Means Equal*.

[34] Hess, *Status of Women in the States*.

[35] For further disaggregated data showing incoming disparities among these ethnic subgroups, see www.dol.gov/wb/images/Asian_Pacific_Islander_Infographic.pdf.

[36] Ibid.

[37] See www.eeoc.gov/eeoc/statistics/enforcement/pregnancy.cfm.

[38] See www.supremecourt.gov/opinions/14pdf/12-1226_k5fl.pdf.

[39] The Commission reissued its Enforcement Guidance on Pregnancy and Related Issues in June 2015 to address the Supreme Court's decision in *Young*.

[40] California, New Jersey and Rhode Island. See www.whitehouse.gov/sites/default/files/docs/leave_report_final.pdf.

weeks and not at full pay. Attempts by the current administration to provide paid maternity leave for federal employees have not yet been successful.[41] The United States is one of only two countries in the world without mandatory paid maternity leave for all women workers.

55. The Working Group is also concerned at the unequal division of family caregiving work, demonstrated by the fact that women are nine times more likely than men to work part-time for family care reasons. Part-time work means lower earnings (and lower social security contributions); part-time workers are also much less likely to have access to paid leave of any kind or to benefit from employer contributions to employer-provided health insurance or pension plans. Women are also three times more likely than men to report having left their job because of caregiving responsibilities (6 per cent compared with 2 per cent, according to a survey of people aged 45-74 undertaken in 2013 by the American Association of Retired People). A study by MetLife (2011) estimated that women with caregiving responsibilities who were over the age of 50 would lose $324,044 in income and benefits over their lifetime if they completely exit the workforce for caregiving reasons.[42] The Working Group considers that the public budget should provide facilities for childcare and after-school care and facilities for the elderly and disabled that are affordable and accessible, to allow adults with care responsibilities—women and men—to work in full-time employment.

56. The percentage of women in poverty has increased over the past decade—from 12.1 per cent to 14.5 per cent—at a higher rate than for men; this has predominantly affected women of colour, single-parent families and older women. As noted previously by other United Nations experts, the subprime mortgage market disparately targeted the poor and, in particular, poor women, thus contributing to the increase in women's poverty.

57. The Working Group suggests that both federal and state governments address this problem urgently, by promoting employment for women, raising the minimum wage and eliminating the wage gap. Residual poverty should be addressed through the social security system and, given the country's economic strength, there should be a policy of zero tolerance for relegating people to poverty.

58. Furthermore, many stakeholders complained that minimum wages have lost value as a living wage. The majority of minimum wage earners are women working full time and as the sole source of income for their families. The Working Group regards the raising of the minimum wage to the level of a living wage to be one of the most appropriate ways both to reduce the wage gap and to reduce poverty among working women. The Working Group welcomes recent efforts by the Government in this regard.[43]

59. The Working Group is also concerned at the situation of the estimated 2.5 million domestic workers in the United States, According to the National Domestic Workers Alliance,[44] the overwhelming number of them are women, frequently immigrant women,[45] many of whom are undocumented. During their visit, the experts heard dreadful testimonies from workers in this group who were victims of verbal and physical abuse and wage theft.

In California, workers who qualify receive 55 per cent of their pay for six weeks, paid for by employee-financed public disability insurance.

[41] See www.whitehouse.gov/sites/default/files/docs/leave_report_final.pdf.

[42] Hess, *Status of Women in the States*.

[43] See www.unece.org/fileadmin/DAM/Gender/Beijing_20/United_States_Beijing_20_Review.pdf.

[44] Submission by the National Domestic Workers Alliance.

[45] See www.immigrationpolicy.org/just-facts/immigrant-women-united-states-portrait-demographic-diversity.

The Working Group welcomes the initiatives taken by civil society organizations to improve conditions for domestic workers through a domestic workers' bill of rights.[46] Wage theft also affects other low-income and migrant workers (such as those in manufacturing, construction and some service jobs). The Working Group welcomes the recent increase in the budget of the Wage and Hour Division within the Department of Labor to support investigations.

60. The Working Group recalls that international human rights standards require establishing social protection floors for core economic and social rights, providing paid maternity leave and taking all appropriate measures to produce de facto equality between all women and men in the labour market. It is not for the Working Group to suggest how these minimum standards should be achieved, but only to point out that the United States, the economic leader of the world, lags behind in providing a safety net and a decent life for those of its women who do not have access to independent wealth, high salaries or economic support from a partner or family.

C. Access to health care

61. The Working Group praises the cconsiderable progress achieved by the adoption of the Affordable Care Act. However, it regrets the absence of universal health insurance coverage. The experts also regret the decision of the Supreme Court to allow states to opt out from the expansion of their Medicaid thresholds, as foreseen by the Act.[47] Too many women pay a high price, sometimes with their lives, for this considerable coverage gap, which has strong regional and ethnic disparities. According to official data from 2015,[48] 28 per cent of the people living in poverty are still uninsured. This affects primarily women and, in particular, African-American and Hispanic women, who are thus prevented from accessing basic preventive care and treatments.

62. Furthermore, immigrants, including immigrant women, must wait five years before they can access Medicaid and undocumented migrants are completely excluded from health care, with the exception of emergency care, including labour and delivery and care available at community and migrant health centres and through HIV/AIDS and maternal and child health programmes. During their visit, the experts observed that Texas and Alabama do not allow immigrants lawfully residing in those states to enrol in Medicaid even after completing the federal waiting period of five years. The experts heard appalling testimonies of migrant women who had been diagnosed with breast cancer but could not afford the appropriate treatment. The Health Equity and Access under the Law (HEAL) for Immigrant Women and Families Act, currently before Congress, would expand access to health care for immigrants, particularly women and children. The Working Group also regretted to learn about the serious inadequacies of health-care facilities to treat women with disabilities, and calls for improvement in this regard.

63. The Working Group deplores the substantial disparities that persist in the prevalence of certain diseases, such as obesity, cancer and HIV/AIDs, according to ethnicity, sex and level of education.[49] Black women, for instance, experience the highest rates of hypertension and obesity compared with other ethnic group.[50] The experts also regret that

[46] See www.domesticworkers.org/ho.neeconomics/.

[47] *National Federation of Independent Business v. Sebelius* (2012).

[48] See www.cdc.gov/nchs/data/nhis/earlyrelease/insur201508.pdf.

[49] Centers for Disease and Control and Prevention, "CDC health disparities and inequalities report—United States, 2013", *Morbidity and Mortality Weekly Report*, Supplement, vol. 62, No. 3 (22 November 2013).

[50] Office of Minority Health, Data Brief No.4, November 2015.

the vast majority of lesbian, bisexual, transgender and intersex persons report having experienced discrimination by health-care providers, including refusal of care, harsh language and physical roughness.[51]

64. The experts are also concerned at the results of a study which showed that, after a period of consistent decline, the suicide rate among women increased between 1999 and 2014 from 4 per 100,000 population to 5.8. Suicide is a very worrying public health issue, and concerned authorities should address it urgently.[52]

Sexual and reproductive health

65. Women's empowerment is intrinsically linked to their ability to control their reproductive lives (A/HRC/32/44). The Working Group would like to recall that according to international human rights standards, including the Convention on the Elimination of All Forms of Discrimination against Women, which the United States has signed but not ratified, States must take all appropriate measures to ensure women's equal right to decide freely and responsibly on the number and spacing of their children, which includes women's right to access contraceptives.

66. The Working Group welcomes the requirement in the Affordable Care Act that new private health plans must cover contraceptive counselling, without out-of-pocket costs. Despite the Government's efforts, and a significant drop in teenage pregnancy, the Working Group remains concerned that the rate of teenage pregnancy is substantially higher than in other Western industrialized nations and that ethnic and geographic disparities in teen birth rates persist.[53]

67. The experts were informed that, being a prerogative of each state, there is no national policy on sex education and adequate and quality sex education in school. Oregon, for example, does provide sex education, but it is lacking in many curricula. According to interlocutors, in many schools only abstinence is taught in place of scientifically based sex education, which is a key element of health policy.

68. Although women have a right under federal law to terminate a pregnancy in various circumstances, including the constitutional guarantee under *Roe v. Wade*, ever-increasing barriers are being created to prevent their access to abortion procedures. Women's access to reproductive health services has been truncated in some states by the imposition of serious constraints. These take the form of unjustified medical procedures, such as compelling women to undergo ultrasounds or to endure medically unnecessary waiting periods; withholding early-pregnancy abortion medications; and imposing burdensome conditions for the licensing and operation of clinics resulting in the closing of clinics across the country, leaving women without access to sexual and reproductive health services. Furthermore, marketplace insurance coverage for the legal termination of pregnancy is far from universal. Thus, insurance will frequently not be available for women who wish to exercise their right to terminate their pregnancy in the first trimester. These restrictions have a disproportionate and discriminatory impact on poor women. As the experts observed during their visit to the Rio Grande Valley in Texas, one of the poorest regions in the country, immigrant women face severe barriers in accessing sexual and reproductive health services.[54] The adoption of the Woman's Health Protection Act would prohibit states from enacting unconstitutional restrictions on reproductive health-care providers that block

[51] Submission by Human Rights Campaign Foundation.

[52] See www.cdc.gov/nchs/products/databriefs/db241.htm.

[53] Seewww.cdc.gov/teenpregnancy/about/index.htm.

[54] See www.reproductiverights.org/document/nuestro-texas-the-fight-for-reproductive-health-in-the-rio-grande-valley.

access to safe and legal abortion services by requiring all hospitals to provide these services and insurance schemes to provide coverage for abortions, to which women have a right under United States law.

69. The Working Group is also concerned that an increasing number of states are targeting women's health providers for exclusion from key federal health programmes, including the Title X Family Planning Program, the Centers for Disease Control and Prevention programmes on sexually transmitted infections under section 318 (of the Public Health Service Act and Medicaid. At least 17 states have taken such action since 2011; 10 of these states have taken official action to block certain women's health providers, such as Planned Parenthood, from participating in Medicaid.

70. In addition, many of the clinics work in conditions of constant threats, harassment and vandalism, too often without any kind of protection from law enforcement officials, as the experts observed during their visits to Texas and Alabama. Alabama has a history of serious violence against abortion providers, including the killing in 1993 of Dr. David Gunn, the first doctor to be murdered for performing abortions in the United States. The massacre in the Colorado family planning centre that occurred just before the start of the visit once again demonstrated the extreme hostility and danger faced by family planning providers and patients. The experts are concerned at the stigma attached to reproductive and sexual health care, which leads to acts of violence, harassment and intimidation against those seeking or providing such care. The Working Group reminds the Government of its due diligence obligation and encourages it to investigate and prosecute violence or threats of violence occurring in this context.

71. The experts reiterate that the enjoyment of the right to freedom of religion or belief cannot be used to justify gender discrimination and, therefore, should not be used as a justification for hindering the realization of women's right to the enjoyment of the highest attainable standard of physical and mental health (ibid.). Laws on religious or conscience-based refusals to provide reproductive health care in the United States should be reconciled with international human rights standards. Refusal to provide sexual and reproductive health services on the grounds of religious freedom should not be permitted where such refusal would effectively deny women immediate access to the highest attainable standard of reproductive health care and affect the implementation of rights to which they are entitled under both international human rights standards and domestic law.

72. The Working Group expresses serious concern at the increase in the maternal mortality rate in the United States. According to the United Nations,[55] the rate increased by 136 per cent between 1990 and 2013. This global number hides distressing ethnic and socioeconomic disparities. African-American women are nearly four times more likely to die in childbirth. States with high poverty rates have a 77 per cent higher maternal mortality rate.[56] Concerned authorities should continue to elaborate adequate policies to address this issue.

73 The Working Group is surprised at the extremely high levels of cesarean deliveries in the United States (32.2 per cent of deliveries).[57] According to the World Health Organization, the ideal rate of caesarean sections should be between 10 per cent and 15 per cent. When medically necessary, a caesarean section can effectively prevent maternal and newborn mortality; however, when the rate goes above 10 per cent, there is no evidence that mortality rates improve.[58] The experts would encourage the concerned authorities to

[55] See http://apps.who.int/iris/bitstream/10665/112682/2/9789241507226_eng.pdf.
[56] See www.hrsa.gov/ourstories/mchb75th/mchb75maternalmortality.pdf.
[57] See www.cdc.gov/nchs/fastats/delivery.htm.
[58] See www.who.int/reproductivehealth/publications/maternal_perinatal_health/cs-statement/en/.

address this issue carefully and take measures to prevent the performance of caesarian sections for non-medical reasons.

74. The Working Group welcomes the progressive policies introduced by several states to promote access to reproductive and sexual health care. A 2014 report[59] provides a compendium of proactive policy solutions on reproductive health issues ranging from access to contraception and termination of pregnancy to promoting comprehensive sexuality education and improving maternal health. Its author recommends that these solutions be widely adopted. The Working Group also notes with satisfaction the law passed in 2015 in Oregon that allows pharmacists to prescribe contraceptives, thus facilitating access to family planning measures.

IV. Gender-based violence and women victims of multiple forms of discrimination

75. Despite the considerable efforts deployed in the past two decades at the legal, institutional and policy levels and some positive achievements to prevent and respond to gender-based violence, stakeholders have unanimously denounced the alarmingly persistent high levels of such violence in the United States.

Poverty and violence

76. The Working Group observed that poverty may result in homelessness, which exposes women to higher levels of violence and vulnerability. During the visit, interlocutors pointed out that victims of domestic violence were often among the homeless, either because they had been evicted as a result of the violence or because they had fled from their violent partner. Solutions should include effective protection orders, increased availability of shelters, housing support, and prioritizing eligibility for aid for single-mother households and those facing heavy unpaid care burdens.

Gun violence

77. The Working Group is troubled at the persistent, fatal consequences for women of the lack of gun control, in particular in cases of domestic violence. Women in the United States are 11 times more likely to be murdered with a firearm than women in other high-income countries. Over the past 25 years, more intimate partner homicides have been committed with guns than with all other weapons combined. When a gun is present in a domestic violence situation, it increases the risk of homicide for women by 500 per cent. In 35 states, persons convicted of domestic violence misdemeanours or subject to restraining orders are not prohibited from acquiring guns. Federal law (and the law in most states) allows domestic abusers and stalkers to easily evade gun prohibitions by purchasing guns from unlicensed, private sellers. Forty-one states do not require all prohibited domestic abusers to relinquish guns they already own.[60]

Minority women

78. The Working Group is deeply concerned at the disproportionate number of women from ethnic minorities, particularly African-American, Native American and

[59] See www.reproductiverights.org/document/moving-in-a-new-direction-a-proactive-state-policy-resource-for-promoting-reproductive-heal.

[60] EVERYTOWN for Gun Safety, "Guns and violence against women: America's uniquely lethal domestic violence problem", 16 June 2014.

immigrant women, who are subjected to heightened levels of violence, including rape and sexual violence (see CERD/C/USA/CO/7-9 and A/HRC/17/26/Add.5 and Corr.1). Relevant authorities stressed the difficulties in obtaining accurate data on various immigrant and refugee communities, who may fear reporting to law enforcement officials. Indigenous women are more than twice as likely as all other women to be victims of violence, and one in three of them will be raped during her lifetime. It is estimated that nearly 80 per cent of the rapes of indigenous women are by non-indigenous men (A/HRC/21/47/Add.1). The experts also deplore reports of police brutality and the increased number of homicides of African-American women by the police.[61]

79. Lesbian, bisexual, transgender and intersex persons face heightened exposure to hate crimes and physical violence. Sexual orientation-based hate crimes made up about 21 per cent of hate crimes reported by law enforcement in 2013 to the Uniform Crime Reporting Program of the Bureau of Justice Statistics. This percentage is probably an underestimate given that a number of lesbian, bisexual, transgender and intersex survivors of hate violence may not report their abuse to the police.[62]

Migrant women in detention centres

80. The Working Group is extremely concerned at the situation of migrant women in detention centres,[63] in particular women with minor children who are in prolonged detention. According to the information received, some detention facilities are not complying with federal mandates and agency policies. Regarding women seeking asylum,[64] the Commission on Civil Rights noted that the expedited removal process was fundamentally unfair as it did not afford detained immigrants the proper ability to obtain counsel and that the process should be improved to ensure that those who genuinely feared persecution could exercise their right to seek asylum in the United States. The Working Group also received allegations of sexual abuse and assault of women detainees, as well as mistreatment by Customs and Border Protection officials. Migrant women are often victims of trafficking and violence, including sexual violence, during their journey to the United States. The experts received complaints that appropriate health-care services were not systematically provided to these women in a timely manner, despite the horrifying physical and emotional ordeals they endured and in violation of detention standards. The experts also received complaints of migrant transgender women being mistreated in detention and often wrongfully placed with males.

Incarcerated women

81. The Working Group shares the concerns expressed by the Special Rapporteur on violence against women, its causes in consequences in the report on her visit to the United States (A/HRC/17/26/Add.5 and Corr.1) regarding women in detention (overincarceration, sexual violence, shackling of pregnant women, solitary confinement, lack of alternatives to custodial sentences for women with dependent children, inappropriate access to health care and inadequate re-entry programmes). The Working Group is also concerned at the negative effects of the Prison Litigation Reform Act on the ability of prisoners to seek protection of their rights; the Act requires prisoners to

[61] See http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=INT%2fCAT%2fCSS%2fUSA%2f18555&Lang=en.

[62] Ibid.

[63] See www.usccr.gov/pubs/Statutory_Enforcement_Report2015.pdf.

[64] Ibid.

exhaust all internal complaint procedures before bringing an action in federal court. While welcoming the adoption of the National Standards to Prevent, Detect, and Respond to Prison Rape, pursuant to the Prison Rape Elimination Act (2003), the Working Group expresses serious concern at reports that their implementation at the state level continues to be a substantial challenge.

Women in prostitution/sex workers

82. The criminalization of women in prostitution/sex workers in most of the country exposes them further to violence, places them in a situation of injustice, vulnerability and stigma and is contrary to international human rights standards. As the Committee on the Elimination of Discrimination against Women has systematically reiterated, women should not be criminalized for being in a situation of prostitution. Furthermore, as stipulated in the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime (the Palermo Protocol), efforts should be deployed to discourage the demand that fosters all forms of exploitation of women.

V. Conclusions and recommendations

A. Conclusions

83. The Working Group greatly appreciates the invitation by the Government of the United States for the visit, which opened the door to an open and frank exchange regarding both good practices and gaps in women's enjoyment of their human rights in the United States.

84. The experts are of the opinion that, in a global context, women in the United States do not take their due place as citizens of the world's leading economy, which has one of the highest per capita incomes. In the United States, women are left behind in terms of international standards as regards their public and political representation, their economic and social rights and their health and safety protections.

85. The experts welcome the genuine support expressed by the current administration for the cause of women's equality and its undertaking to ratify the Convention on the Elimination of All Forms of Discrimination against Women. However, the experts regret the failure to implement these aims. As many stakeholders have underscored, the extreme polarization of politics has profoundly affected the ability of the Government to ratify the Convention and to introduce measures to guarantee women's human rights.

86. At the domestic level, ratification of the Convention is essential in order to provide all women in the United States with the rights and protections guaranteed therein. It is a myth that women already enjoy all those rights and protections under United States law. There are "missing" rights and protections to which women would be entitled under the Convention, such as universal paid maternity leave, accessible reproductive health care and equal opportunity in standing for political election.

87. The United States, which is a leading State in terms of formulating international human rights standards, is allowing its women to lag behind in the respect for these standards. While all women are victims of these "missing" rights, women who are poor; Native American, African-American, Hispanic and Asian

women; women who are members of ethnic minorities; migrant women; lesbian, bisexual, transgender or intersex persons; women with disabilities; and older women are in a situation of heightened vulnerability.

88. The ability to address these challenges is limited by a range of factors. Such obstacles include lack of political will to pass essential legislation; women's limited representation in leadership positions in Congress and in business; a strong conservative religious lobby which opposes reproductive rights; gun lobbies which oppose gun control; and discriminatory gender norms perpetuating a culture that allows discrimination against women to flourish. Women's underrepresentation and negative representation in the media also present major challenges and reinforce existing gender biases.

B. Recommendations

89. In a spirit of cooperation and collaboration, the Working Group makes the following recommendations to the federal and state authorities, as relevant, with a view to strengthening measures designed to guarantee gender equality, the empowerment of women and the promotion and protection of women's human rights.

Legal framework

90. With regard to the legal framework, the Working Group recommends:

(a) Ratifying the Convention on the Elimination of All Forms of Discrimination against Women;

(b) Adopting an equal rights amendment which would entrench women's right to equality in the Constitution;

(c) Reinforcing existing legislation in order to eliminate all forms of sex discrimination in employment, to pre-empt restrictive interpretation of the laws which prejudice women's access to remedies and to allow class action suits for employment discrimination claims on the basis of overall data against large corporations;

(d) Amending the Equal Pay Act to include the right to equal pay for work of equal value, with the implementation provisions recommended in the report of the Working Group submitted to the Human Rights Council at its twenty-sixth session, in 2014 (A/HRC/28/28);

(e) Mandating 14 weeks of paid maternity leave for all women workers in public and private employment, taking into account that best practice is payment from a social security fund which does not impose a direct financial burden on employers;

(f) Ratifying the ILO Domestic Workers Convention, 2011 (No. 189) and applying its provisions to ensure that domestic work is decent work;

(g) Making sure that women can, in practice, exercise their existing constitutional right, reaffirmed in *Roe v. Wade*, to choose to terminate a pregnancy in the first trimester;

(h) Ensuring that the provisions of the Affordable Care Act regarding insured access to contraceptives are universally enforced;

(i) Repealing the Helms Amendment and, in the meantime, issuing an executive order clarifying the scope of the existing legislation and clarifying women's right to insured reproductive health care for termination of pregnancy in cases of risk to life or to health (physical and mental), a pregnancy resulting from rape or other unlawful intercourse, teenage pregnancy or severe fetal impairment;

(j) Repealing the Hyde Amendment;

(k) Adopting the Woman's Health Protection Act;

(l) Disallowing conscientious objection by health-care personnel, providers and insurers to performing procedures to which women are legally entitled and for which there is no easily accessible, affordable and immediate alternative health provider;

(m) Expanding access to health care for immigrants via, for instance, the adoption of the Health Equity and Access under the Law (HEAL) for Immigrant Women and Families Act;

(n) Ensuring that women in prostitution/sex workers are not criminalized;

(o) Amending gun control laws to effectively protect women against gun violence;

(p) Changing laws to ensure that the legal age of marriage is 18, in all cases, for both women and men.

Access to justice

91. **With regard to access to justice, the Working Group recommends:**

(a) Ensuring further gender diversity and gender-sensitive adjudication in judiciaries;

(b) Revisiting and reinvigorating substantive equality for women in court proceedings and ensuring access to justice for all without discrimination, with adequate legal representation regarded as a civil right which, where necessary, should be publicly funded;

(c) Ensuring systematic accountability in cases of police brutality, noting in particular the frequency of police brutality against African-American women;

(d) Empowering Native American tribes to ensure justice in their communities through the exercise of full criminal jurisdiction within their lands;

(e) Ensuring the implementation of the National Standards to Prevent, Detect, and Respond to Prison Rape.

Institutional framework

92. **Regarding the institutional framework, the Working Group recommends:**

(a) Establishing an independent human rights institution in compliance with the Paris Principles, which should include a woman's rights commission;

(b) Establishing a high-level inter-agency working group on human rights implementation with a mandate to oversee and coordinate the implementation of the human rights obligations and commitments of the United States domestically, including the implementation of the recommendations of special procedures mandate holders.

Policies

93. **With regard to public and political life, the Working Group recommends:**

(a) **Applying temporary special measures to ensure gender equality in public and political representation, at both the executive and legislative branches, as well as in the judiciary;**

(b) **Introducing initiatives to encourage the participation of women in elected positions, including by provision of public funding for election campaigns.**

94. **With regard to economic and social life, the Working Group recommends:**

(a) **Developing policies to address occupational segregation, both vertical and horizontal;**

(b) **Providing facilities for childcare and after-school care and facilities for the elderly and disabled which are affordable and accessible to all women without discrimination, to allow adults with care responsibilities—women and men—to work in full-time employment;**

(c) **Raising the minimum wage to a living wage level;**

(d) **Facilitating access to capital and increasing the level of federal contract procurement for businesses owned by women, and taking measures to combat a corporate culture that perpetuates gender stereotypes;**

(e) **Ensuring that the Wage and Hour Division within the. Department of Labor undertakes proper investigations, and increasing supervision to hold employers who violate the rights of vulnerable women workers to account;**

(f) **Addressing the legacies of racism and persistent forms of racial discrimination and ethnic disparities in every sphere of life (inequalities in access to education, employment, housing and health care).**

95. **With regard to health, the Working Group recommends:**

(a) **Increasing funding of clinics under the Title X Family Planning Program in order to expand coverage for low-income women who lack insurance so they can access preventive care, including sexual and reproductive health services, and to reduce maternal mortality;**

(b) **Preventing politically motivated actions to exclude women's health providers from federally supported public health programmes;**

(c) **Taking additional measures to make contraception available and accessible at no cost, in particular for teenagers, with a view to combating teenage pregnancy;**

(d) **Considering reviewing the eligibility requirements for the public welfare system so that the basic human rights of immigrants, including the undocumented, are guaranteed, in particular access to health care for women and children;**

(e) **Addressing the root causes of increased maternal mortality, in particular among African-American women;**

(f) **Ensuring adequate, scientifically based sex education in school curricula;**

(g) Ensuring mandatory human rights education in schools, including the promotion of gender equality, the elimination of violence against women and harmful gender stereotypes as well as the legacy of slavery and racism;

(h) Combating the stigma attached to reproductive and sexual health care, which leads to acts of violence, harassment and intimidation against those seeking or providing reproductive health care, and duly investigate and prosecute violence or threats of violence;

(i) Taking steps to reconcile United States laws on religious or conscience-based refusals to provide reproductive health care with international human rights standards and to prohibit refusal to provide sexual and reproductive health services on the grounds of religious freedom where such refusal would effectively deny women immediate access to the highest attainable standard of health care, and to implement the rights to which women are entitled under both international human rights standards and domestic law.

96. **With regard to violence against women and safety, the Working Group recommends:**

(a) Implementing fully the Violence against Women Act of 2013;

(b) Ensuring effective protection orders, increased availability of shelters, culturally and linguistically responsive programmes and housing support, prioritizing eligibility particularly for single-mother households and those facing heavy, unpaid care burdens;

(c) Ending detention of migrant women with children and establishing accountability mechanisms and adequate gender-sensitive training of Customs and Border Protection officials;

(d) Seeking alternatives to custodial sentences for mothers of dependent children.

97. **With regard to women in the media, the Working Group recommends:**

(a) Strengthening the enforcement of the Federal Communications Commission Equal Employment Opportunity rules;

(b) Promoting the training of journalists regarding gender equality and women's rights, to try to combat harmful gender stereotyping in the media.